INTERIM

RN Guidelines

DIVISION OF IMMIGRATION HEALTH SERVICES

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ABUSE AND NEGLECT

Definition: Abuse: Injurious, harmful or offensive treatment.

Neglect: Omission of due attention.

Red Flag: Look for and note evidence of recent torture and abuse.

If you feel the patient may still be victimized by the abuser, advise ICE.

Carefully document all evidence of suspected torture and abuse, as it may be important to support/refute asylum claims.

Subjective:

1. Using nonjudgmental, declarative statements, ask patient if someone has hurt them either physically, or with words.
   1.1. "How were you hurt?"
   1.2. "Has this happened before?"
   1.3. "When did it first happen?"
   1.4. "How badly have you been hurt in the past?"
   1.5. "Was a weapon involved?" "What kind of weapon?"
   1.6. "Who hurt you?"

Red Flags: Suicidal or homicidal ideation. Increased anxiety, panic attacks, flinching on touch, flat affect, fear, vague complainte without physical findings, feelings of isolation and inability to cope.

Objective:

1. Vital signs,
2. Chart review (Look for documented radiological evidence of abuse, e.g., old fractures),
3. Emotional and Psychological Signs:
   3.1. Irritable,
   3.2. Nervous,

3.3. Anxious,
3.4. Pacing,
3.5. Shouting,
3.6. Crying,
3.7. Cooperative,
3.8. Demanding,
3.9. Suspicious,
3.10. Avoiding eye contact,
3.11. Rigid,
3.12. Clenched fists,
3.13. Other body language and facial expressions.

4. Physical Exam/History: Any signs of injury – frequent sites of injury from abuse: face, neck, chest, breasts, abdomen and genitalia. (Look for evidence of recent torture, abuse or neglect.)
   4.1. Skin: Burns, bruises, old healed scars, fingerprint marks. Look for certain patterns of scarring, black eyes, scalding burns, bruise demarcations, etc;
   4.2. Head: Decreased hearing from multiple blows, subdural hematomas. Feel scalp for wounds or "knots";
   4.3. Eyes: Swelling, subconjunctival hemorrhage.
   4.4. Gastrointestinal: Non-ulcer dyspepsia, irritable bowel syndrome;
   4.5. Genital/Urinary: Bruises, tenderness, history of recurrent vaginitis, dyspareunia, vague pelvic pain, miscarriage, preterm labor, low birth weight delivery, symptoms of rape, or sexual assault;
   4.6. Rectal: Bleeding, edema, irritation, lacerations;
   4.7. Musculoskeletal: Fractures, especially of the face, radius, ulna, ribs; shoulder dislocation; limited motion; old fractures: chronic pain.
5. It is important to use nonblaming language when speaking to victims, or possible victims of violence or neglect. Statements that can be used include:

5.1. "I am concerned for your safety."
5.2. "I am here to help you."
5.3. "It is not your fault."
5.4. "I think I can help you if you will let me in."
5.5. "It is wrong (illegal) to beat another person."
5.6. "You have the right to be treated with respect."

Red Flag: Does the patient have any physical signs of possible abuse –any bruises, cuts, black eyes? Note any in the progress notes.

Assessment:

1. Risk for/actual other-directed violence
2. Risk for trauma
3. Risk for post-trauma syndrome
4. Powerlessness
5. Chronic low self-esteem
6. Ineffective Coping
7. Sexual dysfunction
8. Delayed growth and development
9. Interrupted family processes/impaired parenting

Plan:

1. Provide privacy for patient.
2. Reassure patient that you and the medical staff are there to help them,
3. Remain calm, truthful and nonjudgmental.
4. Cive permission to express angry feelings in acceptable ways. Make time to listen to verbalization of these feelings.
5. Refer patient to NP/PA/MD/DO and/or social worker/psychologist/psychiatrist ASAP.

Evaluation:

Follow-up visit as recommended by consult.

ACNE

Definition: Inflammatory, papulopustular skin eruption,

Usually involving a bacterial breakdown of sebum.

Most often seen in adolescence to early adulthood.

Subjective: Factors influencing patient's condition:

1. Duration of current outbreak;
2. Current medication(s);
3. Current and previous acne treatment;
4. Allergy status;
5. Facial hygiene - how often is patient washing face; and
6. Dietary changes - has there been a recent change in diet.

Objective:

1. Obvious pimples, blackheads, whiteheads, which may or may not be tender to touch;
2. May develop into tender cysts;
3. Usually appears on face, neck, shoulders and back, often in areas of oily skin;
4. May be exacerbated by stress, specific foods, menstruation.

Assessment:

1. Impaired skin integrity
2. Risk for infection
3. Disturbed body image
4. Situational low self-esteem

Plan:

1. Wash attected area with warm soap and water at least tid
2. Shower and shampoo at least daily and atter exercise.
3. Rule out drug eruptions and secondary bacterial intections.

Evaluation:

1. Follow-up prn.
2. It condition worsens or is not improved within 4 weeks, notify Health Services via sick call.
3. For secondary bacterial infections, cysts or severe acne, which is not responding to above implementations, refer to NP/PA/MD/DO.

Education:

1. Avoid using any greasy creams, oils or cosmetics on affected areas;
2. Use OTC acne creams if available from commissary;
3. Avoid touching, picking or squeezing lesions;
4. Teach patient that psychological stress is often associated with increased outbreaks of acne;
5. Educate female patients as to how menstrual cycle hormonal changes may also increase acne exacerbation;

AGGRESSIVE BEHAVIOR – PREVENTION AND MANAGEMENT

Definition: A form of behavior that leads to self-assertion.

May arise from innate drives or as a response to frustration.

May be manifested by destructive and attacking behavior, by covert attitudes of hostility and obstructionism, or by a healthy self-expressive drive to mastery.

Subje ctive: Factors contributing to increased risk for aggressive behavior:

1. Substance abuse.
2. Medication.
3. History of a physical or mental problem.
4. History of aggressive behavior.
5. History of engaging in disruptive, violent or other out-of-control behaviors. Include target of aggression.

Situational variables influencing patient's behaviors may include:

1. Stress from detention.
2. Court decision.
3. Family concerns.
4. Loss of employment.
5. Pending deportation.
6. Interactions with peers.

Cultural issues:

1. Assure that someone is able to communicate with the patient in the patient's own language.
2. Natives of the following locations may be more prone to have outbursts of violent and aggressive behavior or rage:
   Indonesia
   Malaysia
   Papua New Guinea
   Polynesia

Objective:

1. Orientation to person, place, and time.
2. Affect.
3. Motor activity.
4. Speech quality and content.
5. Suicidal or homicidal ideation.
6. Insight.

Assessment:

1. Impaired social interaction.
2. Risk for [/actual] other-directed violence
3. Risk for [/actual] self-directed violence

Plan:

1. Develop and implement an individualized care plan with multidisciplinary input
2. Consider observation (special housing or individual cell).
3. Decrease environmental stimulation.
4. Prepare yourself, your team, the environment for possible acting out:
   4.1. Develop a plan for physical intervention.
   4.2. Work with a team and assure that all team members are aware of their role in this intervention.
   4.3. Gather control over own emotions and feelings.
   4.4. Remove all your own jewelry, pens, neckties, eyewear

before physically intervening with a detainee.

4.5. Remove other patients from the area.

4.6. Move objects that the patient could use to inflict violence, such as chairs or other such objects.

4.7. Draw up medication, if it has been ordered. (Administering medication is the only desirable patient intervention to be undertaken by medical staff.)

5. Provide an opportunity to ventilate and clarify concerns.
6. If physical acting out occurs:
   6.1. Support ICE interventions. Refer to current DIHS, ICE and facility policy regarding seclusion and therapeutic restraints
   6.2. Implement medical Restraint and Seclusion Policy per current SOP
   6.3. Initiate a detainee injury assessment.
   6.4. Notify MD immediately.

Evaluation:

Follow-up within 24 hours and PRN to determine if treatment plan is effective or needs modification

Education:

1. Assure the patient that you will be back to check on them regularly.
2. Calmly explain that you will spend more time once they are calm.

Do not attempt education while the patient is aggressive.

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ALLERGIES

Definition: ***A localized or systemic hypersensitivity reaction that can occur upon exposure to a particular allergen.***

May be caused by pollen, molds, pet dander, dust mites, detergents, chemicals and certain foods.

Subjective:

1. Complaints of:
   - 1.1. Runny nose,
   - 1.2. Congestion,
   - 1.3. Sneezing,
   - 1.4. Red and /or watery eyes,
   - 1.5. Itching bumps on skin,
   - 1.6. Scratchy throat,
   - 1.7. Itching of ear canals or feeling of fullness in ears.
2. History of recent exposure to known allergen(s),
3. Previous allergy treatment history if known.

Objective:

1. Vital Signs;
2. Auscultation of chest, breath sounds;
3. Nose:
   - 3.1. Mucous membrane congestion;
   - 3.2. Edema;
   - 3.3. Itching;
   - 3.4. Rhinorrhea, with clear secretions;
   - 3.5. Sneezing;
4. Eyes:
   - 4.1. Edema;
   - 4.2. Erythema of sclera;
   - 4.3. Dark circles under eyes;
5. Skin:

5.1. Urticaria;
5.2. Pruritis;
5.3. Blotchy erythema on any portion of skin;
6. Cough – if productive, describe sputum

Red Flags: If observed, refer to Anaphylaxis guideline.
Shortness of Breath (SOB),
Wheezing,
Angioedema,
Hypotension,
Tachycardia,
Decreased Level of Consciousness (LOC).

Assessment:

1. Acute Pain [/Discomfort]
2. Risk for impaired skin integrity
3. Deficient knowledge

Plan:

1. Assess ABC's,
   1.1. If anaphylaxis is suspected,
      1.1.1. Support with BLS and
      1.1.2. Notify NP/PA/MD/DO and EMS immediately.
2. Give oral antihistamines such as
   2.1. Chlorpheniramine maleate (Chlortrimeton)
      2.1.1. 4-mg q6-8h, prn symptoms or
   2.2. Diphenhydramine (Benadryl)
      2.2.1. 25-mg p.o. q4-6h, prn symptoms.
3. Give oral antihistamine/decongestant combination such as
   3.1. Pseudoephedrine/Chlorpheniramine/Acetaminophen (Coricidin-D)
      3.1.1. One - Two tablets q8 h, prn allergy symptoms.
4. Treat hives or rash with
   4.1. Hydrocortisone 1% cream
      4.1.1. Applied topically to hives or rash q6h, prn
5. Increase fluid intake (minimum eight 8oz cups of fluids daily).
6. Document any new allergies in patient's health record per policy.

Evaluation:

1. F/U prn unless patient continues to experience symptoms or symptoms are not relieved with above medications.
2. Patient reports no increased symptoms such as wheezing, Shortness of Breath (SOB) or increased edema.
3. Congestion reduced with use of p.o. antihistamines or combination antihistamine/decongestants.
4. Relief of pruritis hives reported with use of hydrocortisone cream and/or p.o. antihistamines.

Education:

1. Teach correct administration and dosage of antihistamines decongestants and topical corticosteroids as prescribed.
2. Instruct patient as to possible life threatening symptoms, which require immediate notification of Health Services.
3. Advise patient
   - 3.1. To avoid outside activities when pollen counts are high.
   - 3.2. To rinse clothes again in clear water upon return from laundry to remove excess detergent residue.
4. Suggest patient purchase and use mild soaps and shampoos such as Ivory, Dove and Johnson's Baby Shampoo from commissary instead of using issued soaps and shampoos.
5. Teach importance of making medical personnel aware of all known medication allergies at each encounter.

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ANAPHYLAXIS

Definition: An immediate, life-threatening systemic reaction that can occur upon exposure to a particular allergen.

May be caused by:

Immunotherapy,
Stinging insects,
Skin testing,
Medications,
Contrast media infusion,
Foods,
Latex, and
Exercise.

Subjective:

1. Ascertain when onset of symptoms occurred and all possible routes of entry of allergens into the body.
2. Determine if patient had recent injection or exposure to substances /allergens capable of causing an allergic reaction.
3. Determine history of allergic reactions to substances/ allergens to which recent exposure may have occurred.

Objective: Sudden onset of any of the following:

Respiratory - Shortness of Breath (SOB), bronchospasm, cough, wheezing.
Cardiovascular - hypotension, tachycardia, palpitations, syncope, cyanosis.
Cutaneous - Urticaria, erythema, pruritus, angioedema (edema of the area surrounding the vasomotor nerves, or center), flushing.
Gastrointestinal - nausea, vomiting, diarrhea, abdominal pain, bloating.
Psychological - distress, severe anxiety.

Assessment:

1. Ineffective airway clearance, related to bronchospasm or laryngeal edema.
2. Decreased cardiac output related to vasodilatation.
3. Anxiety related to respiratory distress and life threatening situation.

Plan:

1. Quickly assess airway, breathing and circulation.
   1.1. If compromised, support with BLS/CPR as indicated.
   1.2. Notify NP/PA/MD/DO and activate the Emergency Medical System (dial 911) immediately if anaphylaxis is suspected.
2. Apply tourniquet above sight of antigen injection, skin test, insect sting to slow absorption of antigen into the system.
3. Per medical provider's orders: Inject Epinephrine 1:1,000 - 0.1 to 0.5 ml injected S.C. or I.M. opposite affected arm. May be repeated every 15 - 20 minutes if necessary.
4. Per medical provider's orders: Establish and maintain adequate airway; administer oxygen 2-5 liter via nasal cannula or by alternate means if ordered or indicated.
5. Per medical provider's orders: Start 18 Ga. IV of normal saline and prepare to administer rapid infusion of IV fluid and/or medications as ordered.
6. Monitor vital signs q 5 min or as ordered.
7. Per medical provider's orders: Insert indwelling catheter to monitor kidney perfusion.
8. Per medical provider's orders: Oral or injectable antihistamines such as diphenhydramine may be ordered once patient has been stabilized.
9. Document any new allergies in patient's health record per policy.
10. Observe all patients for at least 20 minutes in clinic after giving any injectable medication for any possible signs and symptoms of allergic reactions.

Evaluation:

1. Respiration is 28/min. or less; is deep with moderate to no wheezing. Good breath sounds heard throughout all lung fields.
2. Blood pressure within normal ranges;
3. Urine output at least 30cc/hour.
4. Patient is alert, oriented, responsive and cooperative

Education :

1. Instruct patient to read labels and become familiar with both the generic and trade names of any drugs thought to cause a reaction.
2. Teach patient the names and dosages of all medications they may be taking.
3. Tell patient to be aware of potential hidden food allergens in prepared foods if they have known food sensitivity to specific food products such as nuts or shellfish.
4. Stress the importance of making medical personnel aware of all known medication allergies at each encounter.
5. Suggest obtaining "Allergy Alert" bracelet or wallet card upon release from facility.

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ANXIETY

Definition: A subjective feeling of apprehension and tension;

Manifests in a variety of psychophysiologic arousal and behavioral patterns.

Note: Detainees incarcerated in the various ICE detention sites often suffer from situational anxiety. Refugees may be fleeing war and political persecution. Many may be experiencing symptoms of Post Traumatic Stress Disorder (PTSD). The affected person experiences a level of anxiety that interferes with their functioning in personal, occupational or social situations as well as with their psychophysiologic well being.

Subjective: ***Red Flag: Ask the patient directly if they have any thoughts of self harm or suicide. If so, have they develo ped a plan?***

1. Complaints vary from mild apprehension to syncope.
   - 1.1. Determine what specifically is causing the anxiety.
   - 1.2. Determine duration of current feeling of anxiety.
   - 1.3. Ask about previous episodes and triggers.
   - 1.4. Determine history of alcohol or drug abuse?
2. May come to clinic often with somatic complaints:
   - 2.1. Headache,
   - 2.2. GI symptoms, lack of appetite,
   - 2.3. Back or neck pain.
   - 2.4. Dry mouth,
   - 2.5. Tremors,
   - 2.6. Palpitations, chest pain,
   - 2.7. Shortness of Breath (SOB), hyperventialtion.
   - 2.8. Diaphoresis and syncope;

Exams remain negative for disease process.

Objective:

1. May act out: constantly complaining, arguing, other excessive behaviors;

2. May appear withdrawn;
3. Relates feelings of helplessness and/or confusion, apprehension, insomnia, loss of concentration.

Red Flags:

Suicide ideation, especially if they acknowledge a plan;

History or suspicion of recent illicit substance abuse or withdrawal;

Uncontrolled aggression toward others;

History of cardiovascular disease;

History of psychosis, organic brain syndrome or recent head trauma.

Cultural issues:

In Asian culture, a stigma is attached to mental illness and emotional problems may be somatized.

In some cultures, the presentation of their symptoms may be out of proportion (exaggerated) to the actual situation. They may exaggerate their feelings of anxiety while others may remain stoic.

Assessment:

1. Anxiety [severe/panic]
2. Ineffective coping
3. Social isolation related to incarceration;
4. Adjustment impaired:
5. Altered thought process, related to severe anxiety.
6. Insomnia
7. Risk for self-mutilation/self-directed violence

Cultural Issues: Keep in mind cultural influences. Some cultures are stoic and others exaggerate their feelings of anxiety.

Plan:

1. Evaluate potential for harm to self or others. If present:
   1.1. **Refer to NP/PA/MD/DO/Mental Health Provider**

and/or ICE staff immediately.

1.2. **Initiate immediate suicide precautions per DIHS guidelines** .

2. Have patient slow respirations or breathe into paper bag if they are hyperventilating.
3. Assess patient's degree of anxiety based on objective and subjective manifestations.
   3.1. Explore anxiety-producing situations and help patient identify previously successful coping skills, which could be utilized to offset anxiety.
   3.2. Refer to NP/PA/MD/DO for medication and/or referral to Psychiatrist if indicated.
   3.3. Administer prescribed anxiolytics to decrease anxiety level if indicated.
   3.4. Temporarily remove patient from environmental stresses if possible.
4. Instruct patient to notify health services and/or ICE staff immediately if they experience thoughts of harming themselves or others.

Evaluation:

1. Reports no suicide ideation and/or feelings of aggression toward others;
2. Identifies stresses and demonstrates normal heart rate, respiration and subjective feelings of decreased anxiety;
3. Demonstrates improved thought processes through ability to focus and problem solve;
4. Takes anxiolytics as prescribed, correctly demonstrates relaxation techniques. independently performs ADL's. patient exhibits clean dress and good hygiene.

Education:

1. Instruct patient to notify health services and/or ICE staff immediately if they experience thoughts of harming themselves or others;
2. Teach relaxation techniques to diminish distress;
3. Explain causes, symptoms of anxiety and help patient identify and avoid specific events which can lead to increased anxiety;
4. Describe medication regime and expected time frame for desired effects;
5. Define anxiety and differentiate from fear in terms that patient understands;
6. Stress temporary nature of anxiety (if situational).

BRONCHIAL ASTHMA

Definition: Variable, recurrent, reversible airway obstruction;

Intermittent episodes of wheezing and dyspnea.

Extrinsic Asthma – The hyper-responsiveness of bronchi to various allergens;

Intrinsic, Occupational or Exercise Induced Asthma – The hyper-responsiveness of bronchi to environmental stimuli such as air pollution, industrial fumes, dust or chemicals and exercise.

Subjective:

1. Symptoms:
   - 1.1. Wheezing;
   - 1.2. Shortness of Breath (SOB);
   - 1.3. Chest tightness;
   - 1.4. Cough;
   - 1.5. History of asthma and/or allergies;
   - 1.6. Recent exposure to noxious stimuli;
   - 1.7. Recent or current respiratory infection;
2. Duration of current symptoms;
3. Is relief provided by usual medications; date of last use of medication; are steroids used; how frequent is inhaler used;
4. Identify exposures; usual triggers;
5. Severity of prior episodes; was hospitalization required.

Objective:

1. Vital signs;
2. Respiratory rate and depth;
3. Expiratory wheezes to auscultation;
4. Tachypnea and/or cyanosis;
5. Restlessness, anxiety and apprehension;
6. Sa02 less than 97% on room air (if pulse oximeter is available);

7. Non-productive cough;
8. Decreased peak flow meter readings;
9. Use of accessory breathing muscles (more common in children)

Red Flags:

Foreign object in airway,

Fever with recent history of URI,

Acute onset with no previous history of asthma (could indicate anaphylaxis),

History of congestive heart failure,

Wheezing and Shortness of Breath (SOB) not relieved after second nebulizer treatment.

Assessment:

1. Ineffective breathing pattern, related to bronchospasm;
2. Airway clearance ineffective related to increased respiratory secretions;
3. Anxiety related to difficulty breathing, fear of suffocation, death.
4. Impaired gas exchange related to altered delivery of inspired oxygen/air trapping

Plan:

1. Assess vital signs; oxygen saturation and peak flow meter readings (if available)
2. If patient has Albuterol (Ventolin) inhaler already prescribed
   2.1. Administer 2 to 4 puffs STAT
   2.2. May repeat once after 10 min if patient remains symptomatic.
3. If patient does not have Albuterol already prescribed per medical provider's orders:
   3.1. Provide Abluterol premixed nebulizer solution (2.5 mg diluted in 3 ml NS solution);
   3.2. Administer via nebulizer mask or hand held inhaler;

3.3. Repeat if wheezes still auscultated after 20 min and patient remains symptomatic;

4. Per medical provider's orders may use Oxygen instead of room air:
   4.1. To administer nebulizer treatment, or
   4.2. As an adjunct via nasal cannula at 2-4 LPM during acute attack, or if patient appears cyanotic;
5. Instruct patient on positioning – sitting upright, leaning forward to facilitate breathing;
6. Perform chest physiotherapy/postural drainage to help dislodge mucus plugs;
7. Refer to NP/PA/MD/DO for inclusion into Chronic Care Asthma Clinic.

Evaluation:

1. Wheezing absent or reduced;
2. Peak flow and Sa02 improved;
3. Patient verbalizes less anxiety;
4. Patient exhibits respiration and heart rates within normal limits.

Education :

1. Provide information on medications and proper use of inhaler devices, including guidelines to avoid over or under usage;
2. Help patient identify:
   - 2.1. What triggers asthma,
   - 2.2. Warning signs of impending attacks,
   - 2.3. Strategies for preventing future attacks.
3. Instruct patient to:
   - 3.1. Seek treatment for any signs and symptoms of URI's immediately,
   - 3.2. Keep well hydrated;
   - 3.3. Avoid outdoor activities during extreme cold or when pollution levels are known to be high;
   - 3.4. Either avoid situations known to precipitate asthma attacks (exposure to fumes, gases, smoke and particulate matter), or use proper respiratory protection.

BURNS

Definition: ***A form of traumatic injury caused by exposure to thermal, chemical, electrical, or radioactive agents. Burns are classified as follows:***

First Degree: Superficial involvement of epidermis with erythema but without blistering. Sunburn, for example.

Second Degree (Partial thickness): Injuries involve damage to epidermis and upper portions of the dermis, usually resulting in blistering and/or weeping. Scalding, for example.

Third Degree (Full thickness): All layers of the skin and sometimes underlying tissues are destroyed.

The appearance of skin color may vary from white to cherry red to brown or charred black

Often, the area of burn is insensate and hairs may pull out easily. Grafting is almost always required for complete wound closure.

Subjective:

1. History of recent exposure to thermal, chemical, electrical, or radioactive agents.
2. Complaints of pain, redness, and blistering to area of skin exposed to one of the above agents.

Objective:

1. Assess ABC's;
2. Obtain vital signs;
3. Assess for pain, history of medical problems; current medications; allergies;
4. Erythema, weeping, blistering or charring, to area exposed to agents known to cause burns;
5. Area of burn may be more sensitive to touch or insensate depending on thickness of burn;
6. For electrical burns, identify both entrance and exit wounds

to determine approximate pathway and internal organs which may have been affected;

7. Determine the extent of body surface area involved.

Red Flags:

1. Transport to nearest burn center via ambulance immediately:
   - 1.1. Any 3rd degree burn,
   - 1.2. 2nd degree burn larger than an area the size of your hand,
   - 1.3. Electrical burns,
   - 1.4. Chemical burns,
   - 1.5. Circumferential burns to the face, hands, feet or perineum, or
   - 1.6. Suspected airway/inhalation.
2. Shortness of Breath (SOB), hoarseness, stridor or drooling may indicate need for immediate intubation.
3. Smoke inhalation: Observe signs of singed nasal hair or blackened areas around the nose and mouth, dark gray, black or pink tinged sputum;
4. Carbon monoxide poisoning: Headache, nausea confusion, changes in Level of Consciousness (LOC) after exposure to fire in a closed area. Consider carbon monoxide poisoning even if you see a perfect oxygen saturation.

Cultural issues:

Asian practice of "cupping" (placing a cup with a heated rim, over an area of the body) can resemble a burn.

Assessment:

1. Impaired gas exchange related to inhalation injury;
2. Impaired skin integrity related to burn injury;
3. Acute/chronic pain related to burn injuries and skin tightness;

4. Body image disturbance related to functional and cosmetic sequela of burn wound.
5. Risk for deficient fluid volume
6. Risk for ineffective airway clearance
7. Risk for infection
8. Risk for imbalanced nutrition: less than body requirements
9. Post-trauma syndrome
10. Ineffective protection
11. Deficient diversional activity
12. Risk for delayed development

Plan:

First Degree Burns: Refer to RN Guidelines on Pain for OTC medication treatment.

Second Degree Burns:

1. Refer to NP/PA/MD/DO or 911 as appropriate;
2. Check ABC's, vital signs and assess lung sounds (especially if suspicion of smoke inhalation);
3. Remove clothing to ensure no smoldering of undergarments;
4. Thoroughly cleanse wound with normal saline irrigation using aseptic technique and leaving any blisters intact;
5. For minor 2nd degree burns per medical provider's orders:
   - 5.1. Dress with Silver Sulfadiazine (Silvadene) cream,
   - 5.2. Cover with non-stick gauze (Telfa) and
   - 5.3. Cover with dry sterile dressing as needed, or other wound care protocol as ordered by NP/PA/MD/DO
   - 5.4. Evaluate for S&S of infections daily or with each dressing change.
6. Administer pain medications as indicated or ordered. Refer to RN Guidelines on Pain for OTC medication treatment.
7. Administer Td booster if no documentation within 10 years (5 years if burn is contaminated or infected) and document in health record.

Third Degree Burns: Refer to RN Guidelines on Pain for

OTC medication treatment.

1. Refer to NP/PA/MD/DO or 911 as appropriate.
2. Check ABC's, vital signs and assess for lung sounds, singed nasal hair, dark colored sputum, especially if victim was in a closed space and there is any suspicion of smoke inhalation.
   2.1. Notify NP/PA/MD/DO and activate EMS STAT if any suspicion of airway compromise or change in mental status is present.
   2.2. Per medical provider's orders administer high flow (10-15 LPM of oxygen via non-rebreather mask) and prepare for possible intubation prior to transport.
3. Remove clothing to make sure there is no continued smoldering of undergarments;
4. Assess for depth and severity of burns;
5. Per medical provider's orders start IV of Lactated Ringers if time allows;
6. Administer pain medication per medical provider's orders;
7. Per medical provider's orders insert Foley catheter if time allows.

Evaluation:

1. Vital signs are stable and patient exhibits no signs or symptoms of respiratory distress;
2. Patient reports absence of or minimal pain after administration of analgesics;
3. Wound shows no sign of infection and/or remains clean and granulating during healing.

Education:

1. Instruct patient to protect skin from further trauma by limiting sun exposure and using sunscreen, hat, and appropriate clothing as indicated;
2. Teach patient appropriate wound care procedures and have them demonstrate correct cleaning and dressing techniques;
3. Instruct patient to observe burn and report any S&S of infection at wound site, such as, increased redness, drainage, odor, pain or fever.
4. Teach patient about proper dosages, times and indications for medications such as analgesics and antibiotics.

CHICKENPOX (VARICELLA)

Definition: A viral infection characterized by a rash with itching, which begins as red papules and evolves into subsequent tiny central vesicles.

Lesions usually appear first on the head then spread to the trunk and extremities. They may also involve mucus membranes.

Other symptoms may include fever, lethargy or anorexia, which can occur along with, or prior to the appearance of the rash.

This is a highly contagious disease. The patient should be isolated immediately if chickenpox is suspected.

Subjective:

1. Possible exposure to chickenpox during the last three weeks.
2. Previous history of chickenpox.
3. Experiencing fever, malaise and loss of appetite.
4. Appearance of rash and/or complaints of itching.

Objective:

1. Papular or vesicular rash on trunk, head, and extremities.
2. Fever usually low grade.
3. Lesions appear in crops, with rapid evolution (6 – 8 per hour) of individual lesions from macule to papule to vesicle to crusting. All stages of lesions may be present at the same time.
4. Pruritis of lesions may be severe.
5. Rash may be evident in the mucus membranes, such as the mouth, nose and pharynx.

Red Flags: History of allergies, recent drug administration and/or any immune deficiency diseases. Secondary infected lesions (impetigo).

Assessment:

1. Risk for [secondary] infection
2. Skin integrity impaired, related to skin eruptions.
3. Pain related to pruritis and possible mucus membrane involvement.
4. Hyperthermia
5. Deficient knowledge [learning need] regarding contagious nature, condition, transmission, and possible complications.

Plan:

1. Implement current DIHS policy for Varicella
2. Monitor
   2.1. Vital signs and report if significant deterioration until no longer contagious.
   2.2. S & S of secondary bacterial infections of lesions or pneumonia's.
3. Report confirmed chickenpox to Infection Control Provider and/or local health department.
4. Administer
   4.1. Benadryl, one 25 mg. capsule p.o. q.6.h. prn pruritis.
   4.2. May also benefit from topical applications of Calamine lotion PRN
   4.3. Tylenol, two 325 mg. tablets p.o. q.4.h. prn fever.

   Do not give salicylates due to danger of Reyes syndrome.
5. Cut fingernails to minimize excoriation and scarring by scratching.
6. Alert pregnant or non-immune staff members and infection control provider.

Evaluation:

1. Evaluate patient for secondary bacterial infections
2. Continue to monitor and evaluate until chickenpox lesions are completely dry.
3. Evaluate for appropriateness to discontinue isolation

Education:

1. Explain need for isolation to control spread of infection.
2. Discuss importance of not scratching or squeezing lesions, which will minimize potential for secondary infection and scarring.
3. Trimming fingernails will help reduce scratching, especially in children.
4. Advise parents to keep children's immunizations current.

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CONSTIPATION (ADULTS)

Definition: Difficulty in moving bowels and/or increased hardness of stools.

Subjective:

1. Lack of bowel movements or small amount of stool over a period of three or more days.
2. Stool having a hard consistency and/or abnormal color.
3. Complaint of straining with bowel movement.
4. Decreased amount of daily food and fluid intake.
5. Possible recent change in medications or diet.
6. Chronic history, (What treatment has been successful in the past?)
7. Presence of:
   - 7.1. Hemorrhoids.
   - 7.2. Hematochezia (passage of bloody stools),
   - 7.3. Melena (passage of dark colored, tarry stools due to presence of blood altered by the intestinal juices.)

Ask if they are doing anything to cleanse their system. Some cultures, Cuban for example, use purgatives to cleanse their system.

Objective:

1. Vital signs within normal limits for patient,
2. Bowel sounds present in all four quadrants of abdomen.
3. Abdominal distention may be present, especially across lower quads,
4. Note posture and other signs of obvious pain or distress,
5. Hemorrhoids or rectal fissures may be present as a result of straining with bowel movements.

Red Flags: Abdominal pain, lack of bowel sounds, frank blood or melena in stools, nausea, vomiting, history of GI disease and/or peptic ulcers. Refer any of these to NP/PA/MD/DO immediately.

Assessment:

1. Constipation,
2. Constipation Perceived
3. Acute pain
4. Deficient Knowledge

Plan:

1. Have patient increase oral fluid intake with a minimum of eight 8oz cups of fluid, daily,
2. Begin or increase moderate exercise, such as walking,
3. Increase dietary fiber, such as whole grain breads, fruits and vegetables,
4. Augment diet with bulk laxative, such as Psyllium (Metamucil) – one packet mixed in 8 oz of juice or water each day for 7 – 14 days,
5. If primary complaint is hard stools, Docusate 100 mg, 1 capsule p.o. BID or 7 days may be prescribed.
6. Bisacodyl 5 mg tahs, 2 at h.s. for one day (not for maintenance use.
7. Metamucil: Mix one heaping tablespoon in 8 oz of water one to three times per day.
8. If above measures have not promoted B.M. within two days or if constipation is severe, give a one time dose of MOM/Cascara

30cc p.o. and follow up with patient the next day to determine if effective in relieving constipation. If not, refer to NP/PA/MD/DO, immediately.

Evaluation:

1. Patient reports normal passage of soft, formed bowel movements within one week,
2. Patient has no complaints of constipation, nausea, vomiting, diarrhea or abdominal distention within 7 days of prescribing any of the above medications.

Education:

1. Educate patient as to the importance of increased fluid intake and moderate exercise in promoting normal bowel movements.
2. Encourage patient to drink warm coffee or other hot drinks in the morning to initiate B.M. reflex.
3. Assess current diet and instruct patient about increased fiber intake and its relation to good bowel health.
4. Assess patient's current medications and discuss any side effects that could include constipation or other GI complaints.
5. Educate patient that if they are using a purgative frequently, there are some risks and long terms consequences of this practice.

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DANDRUFF

Definition: Dry, itching scalp accompanied by flakes of skin that are noticeable on clothes or when combing hair.

Subjective:

1. Complaint of dry, itchy scalp and or flaking,
2. Duration of symptoms and history of previous treatment. (New or chronic complaint?)

Objective:

1. Scalp appears dry with flakes or scaling of skin that is noticeable on scalp or shoulders.
2. Flakes are easily removed with comb or brush.
3. May occur more frequently where humidity is lacking.

Red Flags: Lice and or nits (eggs) present in hair or on scalp, erythema, weeping, ulceration or papulovesicular rash. Rule out head lice or refer to NP/PA/MD/DO for definitive diagnosis if unsure.

Assessment:

1. Skin integrity impaired, at risk related to scratching,
2. Knowledge deficit related to cause of associated symptoms.

Plan:

1. OTC dandruff shampoo, such as Selenium sulfide, if available from commissary – use as directed,
2. Tar shampoo, initially use daily or every other day, 1-2 treatments/week for maintenance

Evaluation:

1. Patient reports absence or decrease in scalp itching and flaking within 14 days.
2. Return to Clinic (RTC) via sick call if no improvement in 2 weeks or if symptoms worsen.

Education:

1. Teach patient that dandruff is not a serious problem and the symptoms are easily treated.
2. Educate the patient that it may take several weeks for symptoms to clear up and that they may reoccur.

DEPRESSION

Definition: A sinking of spirits with a reduction in level of functioning due to one or a combination of the following:

1. An intensely sad external situation (reactive depression, detention);
2. A genetic defect with neurotransmitter dysfunction;
3. Developmental problems (personality defects, childhood events);
4. A medical condition with associated depression, such as hormonal fluctuations, head trauma, stroke, and many others;
5. May manifest as psychosis (thought disorder).

Subjective: **Document duration of symptoms and treatment history for the following types of depression:**

1. Adjustment disorder with depressed mood (reactive depression)
   - 1.1. Caused by an identifiable stressor or adverse life situation and usually relieved by the removal of the stressor,
   - 1.2. Associated with anger or guilt.
   - 1.3. Symptoms range from mild sadness, anxiety, irritability, worry, lack of concentration, discouragement, and somatic complaints to major depression and dysthymia.
2. Depressive disorders
   - 2.1. Includes major depressive disorder, dysthymia, atypical depression, seasonal affective disorder premenstrual dysphoric disorder, and depression associated with pregnancy.
   - 2.2. Lowering of mood, varying from mild sadness to

intense feelings of guilt, worthlessness, and hopelessness

2.3. Difficulty in thinking, inability to concentrate, ruminations, and lack of decisiveness,

2.4. Loss of interest, with diminished involvement in work and recreation, withdrawal from activities,

2.5. Somatic complaints (headache, disturbed sleep patterns, loss of energy, change in appetite, weight loss),

2.6. Anxiety.

3. Bipolar disorders (manic and depressive episodes)
   3.1. Manic episodes alternate with depressive episodes,
   3.2. Mania manifests as elation with hyperactivity, over involvement in life activities, increased irritability, flight of ideas, easy distractibility, little need for sleep, elation, perception of grandeur.
4. Mood Disorders secondary to illness and drugs

Red Flags: suicidal ideation, homicida l ideation, or a history of suicide attempt, violent behavior, inpatient psychiatric care, or drug use.

Objective:

1. Vital signs and weight
2. Exam directed toward complaints,
3. Observe for sadness, apathy, feelings or worthlessness, self-blame, suicidal thoughts and possible plans, desire to escape, anorexia weight loss, reduction in activity or self care, motor restlessness and anxiety.
4. Look for eye contact, body language, ideas of reference or delusion,
5. Test for orientation,
6. Attempt to find out if the patient has thought about or attempted suicide:
   6.1. "Have you ever thought about taking your own life?"
   6.2. The patient is generally relieved because of the

opportunity to discuss his feelings.

7. Find out if there is an illness, perceived or real,
8. Assess whether there has been sudden worsening of depression.

Cultural Issues: With some cultures, there are stigmas associated with mental illness.

Assessment:

1. [mild, moderate, severe] anxiety/disturbed thought processes
2. Ineffective coping
3. Risk for self-directed violence
4. Risk for other-directed violence
5. Insomnia
6. Social Isolation
7. Interrupted family processes
8. Imbalanced nutrition: less than body requirements
9. Risk for poisoning related to lithium toxicity (bipolar disorder)
10. Disturbed sensory perception

Cultural Issues: Be aware that if a patient appears stoic due to cultural reasons, this does not necessarily mean he/she is depressed.

Plan:

1. Emotional support
   - 1.1. Listen to the patient in a calm, unhurried manner,
   - 1.2. The patient will benefit from ventilation of feelings,
   - 1.3. Give the patient an opportunity to talk about his problems,
   - 1.4. Anticipate that the patient may be suicidal,
   - 1.5. Point out to the patient that depression is treatable,
   - 1.6. Do not leave the patient alone since suicide is usually an act committed in solitude,
   - 1.7. Encourage the patient to make a friend to ventilate to,

and share frustrations.

Evaluation:

1. Refer for consultation with social worker, psychiatrist, psychologist, MD, DO, NP or PA.
2. Give antidepressant and anxiolytic medications as prescribed by psychiatric consultant or MD/DO/NP/PA.
3. Discuss with the MD/DO. Immediate referral to psychiatric unit or psychiatric consultant if patient is at risk for suicide Follow the Suicide Prevention Standard Operating Procedure at all times.

Education:

1. Advise patient to continue daily activities, even if patient does not feel like it,
2. Suggest patient engage in regular exercise, which helps relieve depression,
3. Advise patient to eat at every meal, even if patient does not feet like it. This will not only make the patient feel good, but it may also decrease any side effects from medications, especially SSRIs,
4. Suggest patient maintain good hygiene practices to increase self esteem

DIARRHEA

Definition: Frequent, loose or watery stools.

Greater than three stools in 24 hours
or
More than 250cc of water in stool per day (that is, 1 – 2 cups, 4 – 5 oz)

Symptoms are usually self-limiting.

Subjective:

1. Onset: how many bowel movements in the last 24 hours, associated symptoms (fever, nausea, vomiting, flatus or cramping):
2. Frequency, color and characteristics of bowel movement (frank blood, melena, mucus, greasy, or floating stools, pus or food particles noted in stool).
3. Consistency of stool (soft, formed, liquid, rice water),
4. History of food and fluid intake during the last 48 hours,
5. Recent changes in medications or diet.
6. Review of chart history of GI problems, lactose intolerance and history of any immune deficiency diseases, PUD, trauma, recent antibiotic treatment or recent surgeries.
7. Ascertain if this is a new or chronic problem and what treatments have worked for patient in the past.
8. Anyone else with diarrhea in the immediate surroundings?

Cultural Issues:

Ask if they are doing anything to cleanse their system. (Some cultures use purgatives.)

Objective:

1. Vital signs: check orthostatic blood pressure,
2. Obtain current weight and compare to last recorded weight in health record,
3. Bowel sounds (hyperactive, hypoactive, absent)
4. Abdominal pain, tenderness to palpation and/or distention,
5. Hydration status (mucus membranes, dry lips, skin tenting).

Red Flags: Inability to tolerate p.o. fluids, frank blood or melena in stool, history of any immune deficiency diseases, S&S of dehydration, weight loss more than 5% of baseline, symptoms continuing over 24 hours or abdominal tenderness or distention. Refer to NP/PA/MD/DO for immediate evaluation.

Assessment:

1. Deficient knowledge [learning need] regarding causative/contributing factors and therapeutic needs.
2. Diarrhea, actual vs. perceived
3. Risk for deficient fluid volume
4. Risk for imbalanced nutrition: less than body requirements
5. Risk for impaired skin integrity
6. Risk for infection
7. Acute pain

Plan:

1. Encourage increased clear liquid oral intake to prevent dehydration,
2. Advise oral intake of only clear fluid for 24 hours then easily digested foods (BRAC diet - bananas, rice, apples, cereals and crackers - for the next 24 hours, with gradual resumption of regular diet as tolerated.
3. Bismuth subsalicylate 4 – 8 Tbs. p.o. initially then again after each loose stool. up to 6 times in 24 hours. **Do not give if patient has a fever. Use only if Bismuth subsalicylate**

is ineffective after 24 hours.

4. Loperamide AD (Imodium AD) 4 mg, p.o. initially then 2 mg. p.o. after each loose stool, (maximum dose 16 mg. in 24 hours).

Evaluation:

1. Patient reports decreased watery stools and absence of any other GI symptoms within 24 hours,
2. Patient exhibits no signs or symptoms of dehydration, fever or continued weight loss at follow-up visit.
3. No other detainees in the facility are exhibiting similar symptoms within a 72 hour period.

Education:

1. Advise patient on proper hand washing to prevent the spread of disease,
2. Teach patient about signs of dehydration, i.e., decreased urine output, dry mucus memhranes, decreased skin turgor.
3. Encourage patient to refrain from greasy or high fiber foods for one week or until several normal B.M.s have occurred.
4. Teach that dizziness may be a sign of hypotension,
5. Educate patient that if they are using a purgative frequently, there are some risks and long term consequences of this practice.

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EPISTAXIS

Definition: Nose bleed or hemorrhage from the nose.

Most commonly originates from the anterior portion of the nasal cavity. Posterior nasal bleeding usually originates from turbinates or lateral nasal wall. Postnasal bleeding is less common but usually more difficult to control.

Local causes: dryness leading to crust formation and bleeding occurs when crusts are removed by picking, rubbing or blowing. Sinusitis and rhinitis, as well as trauma, a direct blow to the nose and the long term snorting of cocaine, can also cause it.

Systemic causes that are less common include: hypertension; bleeding disorders; renal disease; liver disease; and arteriosclerosis. These are more likely to cause posterior nasal bleeding.

Subjective:

1. Pt. complains of bloody nose, presents with blood draining from nose.
2. Determine if cause is spontaneous, traumatic or recurring,
3. Complaints of swallowing blood that may be associated with nausea or vomiting,
4. Recent history of direct trauma to nose and/or face, URI, or ENT surgery,
5. History of hypertension, bleeding disorder anticoagulant therapy, or other possible systemic causes,
6. Ask if they are inserting anything in their nose (a possibility with psychiatric patients),
7. History of cocaine abuse?

Objective:

1. Frank blood draining from nose or on tissue (try to estimate amount of blood if severe bleeding),
2. How long has bleeding been occurring,
3. Is bleeding spurting, moderate, heavy, constant or minimal,
4. Obtain vital signs, paying particular attention to pulse and B/P for signs of shock or hypertension.
   4.1. Does patient appear pale, cyanotic or flushed?
5. Dried blood crusted in or around opening of nostrils,
6. Blood draining into the back of the throat from posterior bleed,
7. Bruising of skin, jaundice,
8. Observe septum for perforations that may be a result of cocaine abuse.

Assessment:

1. Risk for impaired tissue integrity.
2. Fluid volume deficit, risk for, related to blood loss from epistaxis.
3. Risk for aspiration,
4. Mild to moderate Anxiety related to situational crisis, threat to health status, interpersonal transmission
5. Knowledge deficit related to treatment of epistaxis.

Plan:

1. Use nasal speculum to visualize hemorrhage if possible,
2. Have patient lean forward and pinch the soft part of the nose with the thumb and index finger, for 10 minutes or more, to maintain pressure on the nasal septum,
3. Per medical provider's orders insert a cotton pledget into affected nostril and apply pressure by pinching as above,
4. Per medical provider's orders a pledget may be soaked with an OTC vasoconstrictive agent such as Afrin or Neo-Synepherine or just Vaseline ointment.

5. Epistaxis not responding to the above treatment after 20 minutes or a suspected posterior hemorrhage should be evaluated immediately by NP/PA/MD/DO for possible cauterization or posterior packing,
6. Address any underlying causes associated with chronic epistaxis such as hypertension. bleeding disorders or recent cocaine abuse.

Evaluation:

1. Patient demonstrates proper technique for controlling mild epistaxis and vital signs are stable,
2. Patient verbalizes understanding of methods that can be used to avoid dryness of the nasal membranes.

Education:

1. Teach patient to avoid blowing or picking nose after nosebleed,
2. For minor nose bleeds associated with dryness, instruct patient to increase the humidity in their immediate surroundings by hanging a moist towel near their head using saline nasal spray prn,
3. Instruct patients prone to minor epistaxis to prevent drying out of mucus membranes by dabbing a small amount of petroleum ointment in their nostrils twice a day,
4. If they have a history of present or past use of cocaine, explain to them the long-term effect/adverse actions. Provide patient with a handout on drug abuse.

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EYE IRRITATION

Definition: Inflammation of the conjunctival surface of the eyeball, eyelid, eyelash follicle or eye socket.

Subjective:

1. Complains of ocular pain, burning, itching, tearing, redness, and/or discharge
2. Defines onset as new, recent or chronic.
3. Describes precipitating events of trauma, foreign object, chemical or smoke exposure, history of hay fever or allergies, contact lens use, new eye makeup, recent surgery, or medication side effect,
4. Identifies associated symptoms of photophobia, discharge from eye (what color), blurred vision, headache, swelling of eyelids or adjacent structure, or allergic symptoms.

Red Flag: History of foreign object in eye (determine nature of particle – wood, metal, etc), eevere p hotophobia, purulent discharge, chemical splash exposure, severe ocular pain, acute visual loss, diplopia or visual changes.

Objective:

1. Vital signs,
2. Visual acuity in both eyes,
3. Eye Exam
   - 3.1. Describe abnormalities,
   - 3.2. Presence of tearing,
   - 3.3. Inability to tear,
   - 3.4. Redness or discoloration,
   - 3.5. Edema,
   - 3.6. Color of drainage or discharge,
   - 3.7. Pupil asymmetry,
   - 3.8. Foreign object,
   - 3.9. Extraocular muscle function and nystagmus,
4. Eyelid Exam
   - 4.1. Describe abnormalities,
   - 4.2. Note presence of redness or discoloration,
   - 4.3. Injury,
   - 4.4. Discharge or drainage,
   - 4.5. Swelling (as with sty or chalazion).

Red Flags: Vision loss, loss of coordinated extraocular movements (EOM) function, proptosis, periorbital cellulitis or facial swelling.

Assessment:

Alteration in comfort related to eye irritation.

Plan:

1. Immediate referral to an MD/DO/NP/PA except for isolated itching with normal visual acuity,
2. For mild irritation, usually due to dry eyes, cigarette smoke, lack of sleep, crying episodes, dust, smog, plant allergens, wind, sun glare, or decreased lacrimation, consider:
   - 2.1. Artificial tears, 1 – 2 drops in affected eyes as frequently as required to relieve irritation,

2.2. If irritation persists, tell the patient to discontinue the medication and return to the clinic for follow-up.

3. Eye irrigation using normal saline solution is indicated to:
   3.1. Irrigate chemicals and foreign bodies from the eye.
   3.2. Remove secretions from the conjunctival sac,
   3.3. Relieve itching
4. For chemical burns, irrigate the eye with copious amounts of normal saline continuously for at least 20 minutes and refer to NP/PA/MD/DO immediately or 911.

Evaluation:

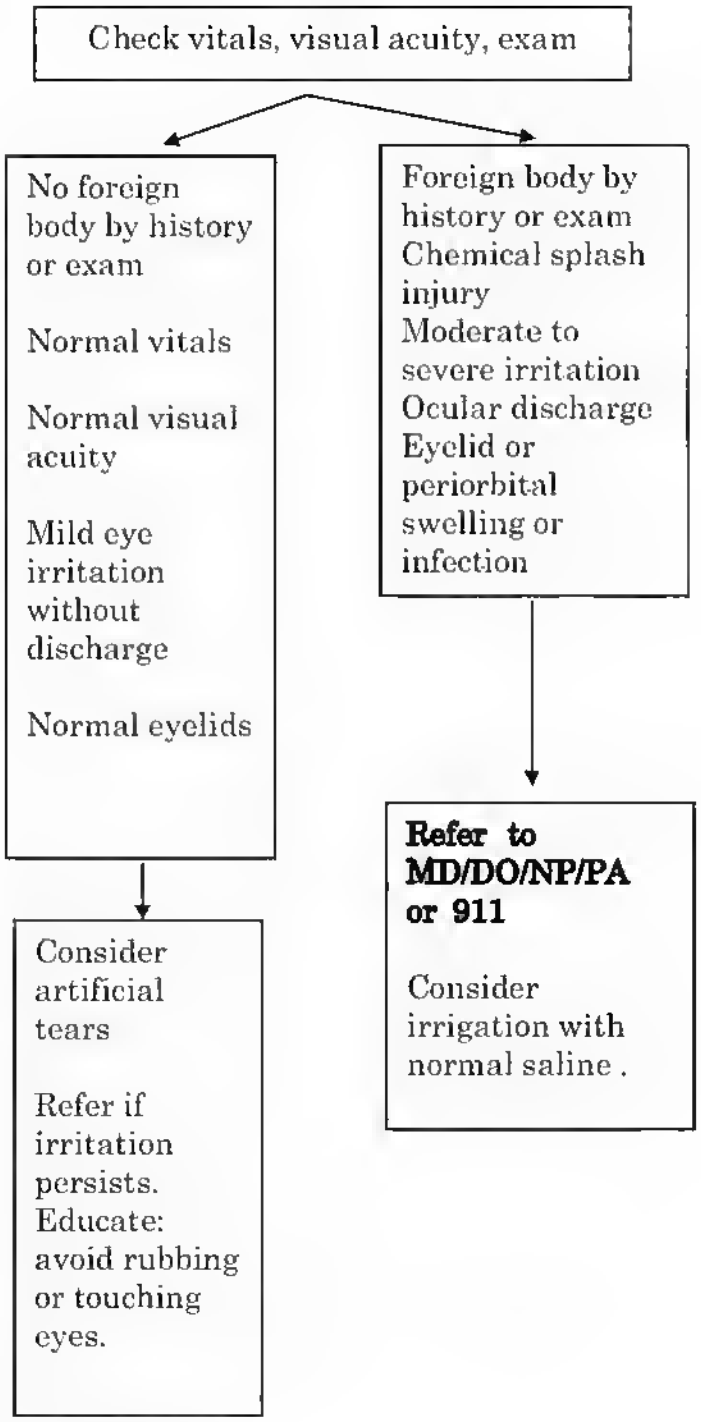
1. Follow up
   1.1. Have patient return to clinic for follow up with MD/DO/NP/PA or on an as needed basis,
   1.2. Follow up with ophthalmologist if needed.
2. Complications
   2.1. Foreign body could be lodged in cornea,
   2.2. Cross contamination from irrigating solution,
   2.3. Eye infection from persistent rubbing of eyes,
   2.4. Patient could damage cornea from touching eye with dropper or tip of medication container.
3. Refer to MD/DO/NP/PA with:
   3.1. Loss of vision,
   3.2. Ocular pain,
   3.3. Failure of therapy with OTC medication within 48 hours.
   3.4. Any complicated problem such as blepharitis, hordeolum, chalazion infective conjunctivitis, iritis, foreign object in the eye, burns of the eye from chemicals or sunlight, or drug and alcohol abuse,
   3.5. Any patient who frequents the clinic asking for eye drops.

Education:

1. Advise patient to avoid touching the eye with fingers or with medication dropper in order to prevent corneal damage,
2. Advise patient not to touch tip of dropper to the eye, surrounding tissue, or any other surface in order to avoid contamination of the solution,

3. Instruct patient that only one person should use the medication. (Very important since detainees frequently share their medications.)

EYE IRRITATION



HEADACHE

Definition: Craniofacial pain of various etiologies, including:
Tension,
Anxiety,
Muscle contraction,
Trauma,
Vascular or migraine,
Intracranial mass lesion,
Intracranial bleeding,
Allergies,
Dental problems,
Sinus congestion,
Otitis or mastoiditis, and
Many others.

Subject ive:

1. History:
   Prior history of similar headaches, migraines, hypertension, sinus problems, allergies, trauma, HIV status and/or risk factors, substance abuse.
2. Location and type of pain:
   Define anatomical site of pain. Define character and duration of pain (throbbing, sharp, dull, achy, pressure-like, constant, intermittent, daily or occasional).
3. Pain scale:
   Rate on scale of 1 (minimal) to 10 (worst).
4. Associated symptoms:
   Question detainee about the following: nausea or vomiting and frequency of such, visual changes, photophobia, dizziness, drowsiness, confusion, seizures, bowel or bladder symptoms, focal weakness, neck stiffness.

5. Medications taken:
   List. Do any medications help with the pain?

Red Flags: History of head or neck trauma, nausea, vomiting, fever, dizziness, visual changes, photophobia, and/or focal weakness, HIV positivity. See algorithm.

If patient complains of "the worst headache I have ever had", refer to NP/PA/MD/DO (possible temporal arteritis, or another medical problem) .

Objective:

1. Vital signs,
2. Exam: Particular attention to mental status (Alert and Oriented X 3, confused, irritable/agitated, lethargic), gait (normal and able to walk or abnormal and unable to walk), pupil size and symmetry, facial symmetry, neck stiffness, focal weakness of one or more extremities.

Cultural Issues: Some cultures may be more vocal and expressive with their symptoms than others.

Red Flags: Fever, abnormal vital signs, altered mental status, pupillary or facial asymmetry, neck stiffnes s, focal weakness or numbness.

Assessment:

1. Acule/chronic pain
2. Risk for ineffective coping
3. Knowledge deficit

Plan:

For tension anxiety headache, consider:
Tylenol 325 mg 2 tablets po q4hours as needed:
Heat to neck 3 times a day as needed.

Eva luation:

1. Return to clinic as needed or per provider request,

2. Third headache presentation should prompt NP/PA/MD/DO referral.
3. Refer to psychologist or psychiatrist for counseling if patient appears to be experiencing a great deal of stress and anxiety.

Education:

1. Explain common causes and avoidance of situations that may aggravate headache. This may be difficult because a patient in a detention facility is in a stressful environment.
2. Describe importance of healthy lifestyle, including diet, sleep, physical activity, smoking cessation, etc.

HEADACHE

History and physical exam

Tension headache: constant dull pain in occipital area or temples, usually related to emotional tension or muscle contraction. Absence of red flags.

Migraine headache: severe, usually throbbing unilateral headache associated with nausea, vomiting, aura, and visual symptoms. **Refer to provider.**

Findings Requiring Referral: Migraine headaches, recent injury, stiff neck, abnormal vital signs, altered mental status, nausea, vomiting, dizziness, fever, facial or pupillary asymmetry, +HIV, any positive red flags.

Consider: Tylenol 325mg 2 tablets q4 hours prn.
Heat to neck tid prn
Education: avoid aggravating situations (stress), promote healthy lifestyle (diet, sleep, physical activity, cut out smoking).
Refer to provider if headaches persist.
Refer to psychiatrist/psychologist for counseling if detainee experiencing a great deal of stress and anxiety.

HEARTBURN AND/OR MILD EPIGASTRIC PAIN

Definition: Transient symptoms of substernal or epigastric pain or burning, usually associated with regurgitation of acid-peptic gastric juice into the esophagus, without a history of peptic ulcer disease.

Subjective:

1. Negative history of peptic ulcer disease or other GI problems,
2. Acute or chronic onset.
   - 2.1. Timing with relation to meals,
   - 2.2. Usually worse with supine position and 30 – 60 minutes after meal,
   - 2.3. Sometimes associated with specific types of food (caffeine, licorice, peppermint) or lifestyle habits (smoking, alcohol) which lower esophageal sphincter pressure,
3. Pain is burning or intermittent in nature, occurring less than two to three times per week,
4. Typically epigastric or suhsternal location,
5. Less than one to two hours duration per episode,
6. Associated symptoms: foul taste in mouth, halitosis, mild epigastric bloating,
7. Treatment history: What has helped this patient in the past?

Red Flags: Fever, weight loss, nausea, vomiting, weakness, hematemesis, hematochezia, melena, constipation, diarrhea or pain in abdomen other than epigastric area.

Cultural issues:

1. Assess cultural and religious patterns,
2. Immigrants may be experiencing changes in diet due to detention and change in culture. Daily

eating patterns and unavailability of traditional foods may cause significant dietary change.

3. Haitians sometimes c/o "gaz" that moves around the body. Have the patient describe discomfort, in detail.

Objective:

1. Vital signs, including weight,
2. May have mild epigastric tenderness, otherwise comfortable and well hydrated.
3. Check for normal, active bowel sounds.

Red Flags: Abnormal vital signs, dehydration, malnutrition, jaundice, or abdominal tenderness other than mild epigastric tenderness. If symptoms of heart attack (MI), refer immediately.

Assessment:

Pain, abdominal, related to heartburn.

Plan:

Mylanta/Maalox, 15-60 ml/dose every 3-6 hours or 1 and 3 hours after meals and at bedtime., for up to one week.

Evaluation:

1. Symptoms should improve within one week.
2. Refer to MD/DO/NP/PA if symptoms last longer than one week or if detainee experiences gastrointestinal bleeding, anemia, weight loss, difficulty swallowing, vomiting or uses large amounts of antacids.

Education:

1. Educate detainee regarding lifestyle changes
   1.1. Frequent, small feedings,
   1.2. Avoid food 2 hours before bedtime,
   1.3. Elevate head of bed,
   1.4. Lose weight, if indicated,
   1.5. Avoid cigarettes and caffeine,
   1.6 Avoid tight clothing around abdomen and chest.

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HEAT EXHAUSTION

Definition: Characterized by dehydration, sodium depletion, or isotonic fluid loss with accompanying cardiovascular changes.

Results from prolonged heavy activity with inadequate salt and water intake in a hot environment.

Subjective:

1. Increasing fatigue, weakness, anxiety and drenching sweats,
2. History of heat exposure, failure of hydration, absence of other apparent cause,
3. May complain of thirst, headache, paresthesias and impaired judgement,
4. Heat cramps may accompany heat exhaustion.

Objective:

1. Document duration of symptoms,
2. Patient may have dry and hot skin from loss of ability to sweat,
3. Rectal temperature usually over 100 Degrees F (37.8 C), tachycardia, tachypnea,
4. Peripheral temperature usually below normal,
5. Exam consistent with dehydration associated with history and symptoms.

Red Flags: Immediate referral to emergency room if: Circulatory collapse as indicated by slow thready pulse, low or impercep tible blood pressure, cold, clammy, pale skin, disordered mentation followed by a shock-like unconsciousness, absence of sweating, rectal temperature at or above 105.8 (41 C).

Assessment:

1. Body temperature regulation impaired related to heat exposure/heat exhaustion.

2. Deficient fluid volume

Plan:

1. Immediately refer to the emergency room if circulatory collapse is suspected.
2. Reassure patient that he will feel better soon.
3. Give small amounts of cool, slightly salty fluids such as oral rehydration solution, Pedialyte or Gatorade to restore normovolemia.
4. Have patient lie flat in a cool, dark place, with head down,
5. Rest and hydrate until voiding.
6. Per medical provider's orders: if indicated, begin 18 gauge IV and intravenous normal saline 1000cc.
7. Notify NP/PA/MD/DO if any red flag is present to avoid converting hyperexia to hypothermia.

Evaluation:

Reversal of symptoms with resolution of hypovolemia and return of adequate urine output.

Refer to an emergency room if patient does not immediately respond to above treatment.

Education:

1. Keep out of the sun for extended periods of time,
2. Keep well hydrated, drink at least 8 eight oz cups of water per day,
3. Rest frequently.

HEAT STROKE

Definition: Failure of the thermoregulatory mechanism, permitting core (rectal) temperature to approach 105.8 degrees F (41 degrees C). Morbidity and death can result from cerebral, cardiovascular, hepatic, or renal damage.

Hallmarks:

Cerebral dysfunction with impaired consciousness,
High fever (hyperthermia), and
Absence of sweating.

Classic heat stroke occurs in patients with compromised homeostatic mechanisms or lack of access to hydration in a hot environment.

Exertional heat stroke occurs in previously healthy persons undergoing strenuous exertion in a thermally stressful environment.

Heat stroke, unless promptly and energetically treated, results in convulsions and death. Immediate ER referral is indicated.

Subjective:

1. History of exposure to a hot environment.
2. Abrupt onset is sometimes preceded by:
   2.1. Prodromal headache,
   2.2. Vertigo, and
   2.3. Fatigue.

3. At greatest risk are:
   3.1. The elderly or chronically infirm,
   3.2. Those with impaired mobility,
   3.3. Alcoholics,
   3.4. The very young, and
   3.5. Persons taking medications that interfere with heat-dissipating mechanisms, such as: anticholinergics, antihistamines, and phenothiazines.

Objective:

1. Temperature climbs rapidly to 40 or 41 degrees C (104 to 106 degrees F) and the patient feels as if he/she is burning up. **106 degrees F is a grave prognostic sign.**
2. Tachycardia may reach 160-180 beats per minute.
3. Sweating is usually but not always decreased.
4. Skin is hot, flushed, and usually dry.
5. Tachypnea.
6. Disorientation may briefly precede unconsciousness or convulsions.

Assessment:

1. Hyperthermia
2. Decreased cardiac output

Plan: Initiate immediate treatment:

1. ***Call 911, MD/DO/NP/PA*** **Transport to an emergency room as soon as possible (activate EMS or ambulance service).**
2. Per medical provider's orders: oxygen, via non-rebreather mask 10-15 L / minute
3. Remove as much clothing as possible,
4. Apply tepid water to skin surface,
5. Per medical provider's orders: start intravenous normal saline or lactated ringers
6. Check temperature (rectal) every 10 minutes.
7. Do not allow temperature to fall below 38.3 degrees C (101

degrees F).

8. Take vital signs every 15 minutes.
9. Provide emotional support and reassurance.

Evaluation: Temperature lability may be expected for weeks.

Bed rest is desirable for a few days.

Education:

1. Advise patient to avoid prolonged exposure to high ambient temperature, especially if the patient is on certain medications, as listed above.
2. Explain importance of keeping hydrated.
3. Explain danger of exercise or strenuous activity in a hot environment.

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HEMORRHOIDS

Definition: A varicose condition of the external hemorrhoidal veins causing painful swellings at the anus. Also called piles.

Subjective:

1. Constant, mild pain, itching, and irritation of the anus aggravated by defecation and sitting.
2. Bleeding may occur from an external hemorrhoid if the varix ruptures. Describe the color and quantity of blood lost.
3. May be an acute condition or chronic.
4. May have constipation or diarrhea.
5. Ask about straining at stool, or occupations with prolonged sitting.
6. Review past history of hemorrhoids and treatment.
7. Review dietary and fluid intake history.
8. Attempt to find out if they are having, or have had anal sex, which may be irritating their hemorrhoids.

Objective:

1. Vital signs are normal.
2. Exam reveals a bluish, firm (thrombosed) varix that protrudes around the anus and is covered with skin (acute condition). May take up only a small area around the anus or may surround it completely.
3. Chronic external hemorrhoids may appear as painless swellings (tags) which may appear when the patient strains when defecating and disappear.
4. During the exam, assess for other conditions that may be causing the complaints, such as condyloma acuminatum (venereal warts), condyloma latum, or other skin findings.

Red Flags:

Temperature > 101 F,

Active bleeding,

Severe pain,

Purulent malodorous discharge (i.e. ruptured perirectal abscess),

Inflamed external protrusions or skin tags,

Or other finding on exam not consistent with hemorrhoids.

Prolapse of an internal hemorrhoid may require surgery. Refer to MD/DO/NP/PA.

Assessment:

1. Acute pain
2. Constipation

Plan:

1. Consider:
   - 1.1. Hemorrhoidal suppositories (Anusol, glycerine formula). Insert one suppository into the rectum after each bowel movement. Advise the detainee to remove the wrapper prior to insertion.
   - 1.2. Metamucil powder, mix one heaping tablespoon with 8 oz of water once a day.
   - 1.3. Docusate 100 mg capsule, take one capsule PO BID for 7 days.
2. Advise detainee to avoid straining when defecating.
3. Treat constipation as necessary.

Evaluation:

1. Return if pain increases and/or bleeding begins or increases.
2. Return as necessary for recurrence of symptoms.
3. Refer to MD/DO/NP/PA for bleeding after defecation, prolapse of an internal hemorrhoid, or if conservative treatment is ineffective.

Education:

1. Provide dietary counseling to:
   1.1. Increase fluid (6 to 8 cups, 8 ounces each, of water per day),
   1.2. Increase fiber in diet (cereals, grains, fruits, and vegetables).
   1.3. Limit intake of foods that may lead to constipation.
2. Advise detainee to avoid straining when defecating.
3. Discourage anal sex.

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HIV COUNSELING

Definition: Human Immunodeficiency Virus (HIV)

A viral disease that can cause an immunodeficiency syndrome (Acquired immunodeficiency syndrome - AIDS),

Characterized by severe immune deficiency resulting in:

Opportunistic infections,

Malignancies, and

Neurologic lesions in individuals without prior history of an immunologic abnormality.

Only an RN who has received special training and achieved supervisory signoff for HIV counseling on the competency checklist can provide HIV counseling.

Subjective:

1. If the detainee requests HIV testing, what are his/her reasons (e.g. multiple sex partners, homosexual encounter, contact with another persons blood, received a blood transfusion, history of a sexually transmitted disease (STD), had a tattoo, or piercing, illicit drug use - especially injectable drugs, had sex with a prostitute, etc.),
2. Experiencing weight loss,
3. Experiencing night sweats,
4. Noticed any swelling under their arms, or in their groin area,
5. Noticed if lacerations, or wounds are taking a longer than normal time to heal.
6. Has patient ever been tested for HIV before and if so, when and what were the results.
7. Ask the patient what he/she knows about HIV.

Objective:

1. Review chart for any medical information that may indicate patient is HIV positive.
   1.1. Note any history of STD and any treatment given. Check if a physical exam has been done on the patient; was lymphadenopathy; oral thrush, or skin lesions (Kaposi Sarcoma) noted?.
2. Note whether patient is nervous or attentive, and type of mood he/she is in.

Assessment:

1. Alteration in immune status due to possible infection with HIV.
2. Risk-prone health behavior
3. Deficient knowledge

Plan:

1. During counseling session provide patient with privacy;
2. Obtain informed consent for test:
   2.1. Advise patient you will be talking to him/her about testing for HIV.
   2.2. Emphasize this information will be kept confidential;
   2.3. Emphasize that the alien number, not their name, will be associated with the blood specimen.
   2.4. Encourage them to ask questions anytime.
3. Follow DIHS Checklist for HIV counseling.
   3.1. Explain all sections fully to the patient, in his/her own language;
   3.2. Assure the patient has tbe opportunity to ask questions,
   3.3. Place completed checklist in patient's chart
4. Advise the patient that he/she will be called to the clinic in approximately one week to learn the results of the HIV test. Again emphasize the results are confidential.

5. Discuss *'need for others to know'* if results are positive.
6. Remind patient that medications and treatment are available to prolong their lives.
7. Provide reassurance and emotional support.

Evaluation:

Schedule follow-up visit for patient in one week with NP/PA/MD/DO.

Make an appointment with the mental health for counseling if the test is positive.

Education:

1. Assure patient is provided with written information - in his/her own language, if possible.
2. Explain how HIV is transmitted and recommend safe sexual practices.

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HUNGER STRIKE

Definition: The voluntary act of refusing to take oral feeds or fluids.

A hunger strike is defined when a detainee declares to a staff member or is observed by a staff member to be refraining from eating and/or drinking for a period of time ordinarily in excess of 72 hours.

Subjective:

1. Obtain a history as to how long the detainee has been on a hunger strike and why.
2. What kind of hunger strike? (Partial fast, total fast, taking liquids).
3. History of previous hunger strikes and duration of each?

Cultural issues:

Verify that patient is not on fast (hunger strike) for religious reasons (i.e. Rosh Hashanah).

Objective:

1. Record Vital signs, including weight.
2. Examine for signs of
   - 2.1. Dehydration,
   - 2.2. Jaundice,
   - 2.3. Electrolyte imbalance,
   - 2.4. Mental status changes,
   - 2.5. Mental illness (depression or psychosis), and
   - 2.6. Organ failure (renal failure).
3. Assess progression of deterioration - progression occurs as follows:
   - 3.1. Weight loss,
   - 3.2. Skin becomes dry and tents,
   - 3.3. Poor mouth hygiene leading to halitosis,
   - 3.4. Sallow appearance,
   - 3.5. Output greater than input.
   - 3.6. Weakness,
   - 3.7. Fatigue.

3.8. Dizziness,
3.9. Concentrated urine,
3.10. Tremors.
3.11. Deterioration of mental status,
3.12. Negative nitrogen balance,
3.13. Eventual breakdown of all body systems.

Age Specific: Keep in mind that children, or the elderly, may deteriorate rapidly

Assessment:

1. Alteration in nutritional status/ body fluid status related to anorexia/ hunger strike.
2. Rule out organic etiology such as cancer, HIV, gastrointestinal problem, mental illness, which may be causing the detainee not to eat.
3. Rule out fasting due to religious beliefs.

Plan:

1. Refer to Hunger Strike Protocol in Policies and Procedures Manual.

Evaluation:

1. Work closely with mental health personnel, Immigration and interpreters to find an immediate solution,
2. Watch for complications, including severe dehydration, kidney failure, electrolyte imbalance, and deterioration of mental health status.
3. At the end of the hunger strike, follow -up of nutritional and mental health status is appropriate.
4. Follow up by mental health consultant.

Education:

Educate the detainee that failure to eat and drink could result in an immediate, significant hazard to their health and well being. so it is important to eat and drink as normal.

IMMUNIZATIONS

Definition: A series of intentional vaccinations to confer resistance to infectious agents.

A primary series is usually given during infancy and childhood consisting of DPT, IPV, MMR, Hib, and HepB.

Booster vaccinations may he needed later in life.

PPD does not confer immunity but is included in this protocol.

Subjective:

1. Patient requires immunizations, as described below.
2. Review chart for immunization history.

Objective:

1. Note vital signs and general state of health.
2. Examine patient pertaining to the needs of the detainee, as described helow.

Cultural Issues:

Keep in mind that in various religious practices. immunizations may not be allowed.

Assessment:

Risk for infection

Deficient knowledge related to immunizations

Plan:

1. Refer to DIHS Policy and Procedures for immunizations.
2. Tetanus prophylaxis (Dt - adults) to be given within 72 hours of injury.
3. See current DIHS Infection Control Manual for TB screening with TST.
4. All detainees under the age of 18 are immunized, except when contraindicated, or where deferred.
   4.1. Immunizations start from birth through 6 years of age according to CDC guidelines. Those over 6 years of age

are also immunized in the same manner, except for the use of Dt instead of DPT.

4.2. All unaccompanied minors are considered not to have been immunized in their country of origin and are started on the primary series from the beginning of their detention.

5. The forms, specific for each facility, are completed per the medical facility's specific format. The consent form is signed by the ICE Administrator in the case of unaccompanied minors.
6. Consult an NP/PA/MD/DO, if immunizations are to be deferred. Immunizations may be deferred if the detainee:
   6.1. Has an acute febrile infection or illness;
   6.2. Had a serious reaction to the vaccine before;
   6.3. Takes a drug or is undergoing a treatment that lowers the body's resistance to infection (e.g., cortisone, prednisone, etc.)
   6.4. The common cold without a fever is not a contraindication. Consult a physician if in doubt.
7. A physician should be consulted concerning any detainee needing immunization who is pregnant or has an immunosuppressed condition.
8. MMR (requires consult with MD/DO) should not be given to:
   8.1. Pregnant women;
   8.2. Persons with allergy to neomycin;
   8.3. Persons with allergy to eggs.
   8.4. Persons with AIDS, or severely immunocompromised condition (e.g., leukemia. cancer, etc.)
9. Refer to RN Guidelines on Pain for OTC medication treatment.

Evaluation:

1. With injectable vaccines, soreness, swelling, and redness may exist where the injection was given, usually lasting 1 to 2 days.

2. DPT complications:
   2.1. Common,
   Some children may be cranky, drowsy, or not want to eat during this time;
   2.2. Not often,
   Crying without stopping for 3 hours or longer may occur;
   2.3. Less often,
   Temperature of 105 degrees F or higher;
   An unusual, high pitched cry;
   2.4. Even less often,
   A convulsion (seizures, fits, spasms, jerking, itching, or staring spells) usually from high fever post injection; Pertussis should not be administered to children with uncontrolled seizures
   2.5. Shock, collapse, and death.
3. IPV Complications:
   3.1. Rarely, causes an allergic reaction;
   3.2. Do not give IPV if patient has ever had life-threatening allergic reaction to the antibiotic neomycin, streptomycin, or polymcin B.
4. MMR complications:
   4.1. Rare, brief convulsion, usually occurs 1 to 2 weeks after the vaccine and usually results from a fever;
   4.2. Rare, hearing loss,
   4.3. Rare, encephalitis (usually resolves completely),
   4.4. Rare, death,

4.5. Occasionally, a rash may occur 1 to 2 weeks after measles vaccine,

4.6. Fever of 103 degrees F or greater may occur 1 to 2 weeks after vaccine, lasting 1 to 2 days,

4.7. For mumps and rubella vaccine, possible glandular swelling may occur immediately or 1 to 2 weeks post injection,

4.8. Mild pain or stiffness in the joints may last up to 3 days, may happen immediately or 1 to 3 weeks post injection,

5. Consult Pharmaceutical Manual or physician for other adverse reactions.

Education:

1. Provide patient (parent, guardian, or custodian if underage) with educational handouts, if possible in their native language.
2. Emphasize to parent, guardian or custodian the importance of keeping the minor's immunizations updated.
3. Advise patient to call clinic if complications from immunizations are experienced. If severe reaction (difficulty breathing, wheezing or swelling of the throat) advise patient to call 911.

INSECT BITES

Definition: Suspected or known contact with a stinging or biting insect.

Morbidity and mortality due to venom, infection, or anaphylaxis.

Subjective:

Spiders Although all spiders are venomous, the fangs of most species are too short or fragile to penetrate the skin.

Widow spiders (dangerous)

1. Sharp pinprick-like pain in the affected extremity.
2. Cramping pain and some muscular rigidity in the abdomen, shoulders, back, and chest.
3. Restlessness, anxiety, sweating, headache, dizziness, ptosis, eyelid edema, skin rash, pruritis, respiratory distress, nausea, vomiting, salivation, weakness, and increased skin temperature over affected area.

Brown or violin spiders (dangerous)

1. Causes little or no immediate pain, but some localized pain develops within an hour or so.
2. Bite area becomes erythematous and ecchymotic.
3. Bleb forms, may increase and fill with blood, punctures and leaves an ulcer over which a black eschar forms, eventually sloughs leaving a large tissue defect.

Bees, wasps, hornets and ants

1. Pain, erythema, and urticaria may occur.
2. Stingers may remain in the skin.

Biting anthropods

1. Among the most common biting and sometimes bloodsucking arthropods in the United States are
   - 1.1. Ticks,
   - 1.2. Mites,
   - 1.3. Sand flies,
   - 1.4. Horse flies,
   - 1.5. Deer flies,
   - 1.6. Mosquitoes,
   - 1.7. Fleas,
   - 1.8. Lice,
   - 1.9. Bedbugs,
   - 1.10. Kissing bugs, and
   - 1.11. Certain water bugs.
2. The composition of the saliva of these arthropods varies considerably and the lesions produced by these animals vary from a small papule to a large ulcer with swelling and acute pain.
3. Dermatitis may occur.

Centi pedes and millipedes

1. Can inflict painful bite with some localized swelling and erythema
2. Lymphangitis and lymphadenitis are common.
3. Symptoms and signs seldom persist for more than 48 hours
4. Millipedes do not bite, but when handled may secrete a toxin that can cause local skin irritation and, in severe cases, tissue changes.

Scorpions

All North American scorpions except **Centruroides sculpturatus** are relatively harmless, stings causing no more than localized pain with minimal swelling and lymphangitis with regional lymph gland swelling. Increased skin temperature, tenderness around the wound and localized tissue reaction may occur.

Sculpturatus species (dangerous)

Found in Arizona, New Mexico, and the California side of the Colorado River

1. Sting causes immediate pain and possibility of numhness or tingling over the involved part.
2. No swelling is present.
3. Children may become tense, restless, and display abnormal and random head, neck, and eye movements.
4. In adults, tachycardia, hypertension, tachypnea, weakness, and motor disturbances may predominate.

Objective:

1. Vital signs,
2. Examine patient, focusing on the nature of the injury, as described above.
3. Consider possible MRSA infection if claims "spider-hite"

Assessment:

1. Alteration in comfort related to insect bite,
2. Skin integrity impaired related to insect bite,
3. Cardiovascular/neurologic/respiratory compromise actual/potential related to insect bite.

Plan:

1. Consider possible MRSA infection if claims "spider-bite". Call MD/DO.
2. **Tetanus shot may be indicated.** Consider every break in the skin as a potential portal of entry for C. tetani.
3. **Routine safety and sanitation inspections conducted by ICE & DIHS**
   - 3.1. Make sure screens are in place for detainee protection.
   - 3.2. Clean environment in dormitory, toilet, shower area and food service to reduce insect population
   - 3.3. Proper disposal of trash must be maintained; trash can covers should he properly affixed to preclude insect attraction and breeding.
   - 3.4. Proper maintenance of sewage.

Black widow spider & Brown or violin spider

1. Notify Medical provider on-call
2. Provide emergency supportive measures as appropriate and ordered by the provider

Bees, wasps, hornets and ants

1. Stinger may remain in the skin and should be removed by teasing or scraping rather than pulling.
2. Ice cube placed over sting will reduce pain.
3. Calamine lotion daily.
4. Hydrocortisone cream 1% to area bid for local relief.
5. May need oral antihistamine per provider order.
6. Refer to RN Guideline on Pain, for OTC medication treatment.

Biting arthropods

1. Do not remove.
2. Call MD/DO.

Centipedes and millipedes

1. An ice cube will control the pain of most centipede bites.
2. Toxic secretions of millipedes should be washed from the skin with copious amounts of soap and water. Alcohol should never be used.
3. Hydrocortisone cream 1% should be applied if a skin reaction develops.
4. Eye injuries require immediate irrigation and should be referred to the NP/PA/MD/DO.

Scorpions

1. Call MD/DO.

Evaluation:

1. Watch for complications including:
   - 1.1. **Anaphylactic shock** in a hypersensitive person from bee sting;
   - 1.2. Systemic signs and symptoms from brown or violin spider bite, including **nausea, vomiting, malaise, hemolysis, thrombocytopenia, kidney failure, and rarely, death;**
   - 1.3. **Serious hypersensitivity reaction** to biting

arthropods;

1.4. **Infection** from bites if not properly cleansed;

1.5. Tick **paralysis** leading to bulbar or respiratory paralysis;

1.6. **Respiratory difficulties** in children and adults, often accompanied by **excess salivation** , caused by **Sculpturatus scorpion** bite.

2. Follow up per MD/DO to check on detainee condition.

Edu cation:

1. Wear long pants and shirts when possible.
2. Avoid areas of heavy foliage.
3. Avoid colognes, perfumes, hair spray, etc.
4. Avoid walking barefoot.
5. Avoid placing hands in corners or other dark areas where insects may hide.

LICE

Definition: Infestation with members of the ectoparasitic insect orders Anoplura and Mallophaga.

Subjective:

1. Intense itching of the affected area (scalp, body, or puhic area).
2. Note the duration of symptoms.

Objective:

1. Head lice (Pediculus humanus capitis):
   - 1.1. The nits (ova) are seen as small (1 to 2mm) oval objects attached to the base of tbe hair; Looks like dandruff which cannot be brushed off;
   - 1.2. The lice are very difficult to find;
   - 1.3. Secondary changes in the scalp, including inpetiginous changes and furuncles, often develop;
2. Body lice (Pediculus humanus corporis):
   - 2.1. Are rarely found on skin but may be present in clothing;
   - 2.2. Skin lesions are characterized by changes secondary to scratching and by secondary impetiginous lesions and furuncles.
3. Genital or pubic lice (Phthirus pubis):
   - 3.1. Nits especially affect the pubic hair;
   - 3.2. Similar in appearance to head lice and;
   - 3.3. Lice are often difficult to find.

Assessment:

1. Impaired skin integrity
2. Risk for infections [spread]
3. Impaired self-hygiene maintenance
4. Acute pain

Plan:

1. **Pyrethrin Shampoo (R&C, RID)**
   - 1.1. For head lice, the medication is applied only to the hair on the head.
   - 1.2. For body lice, enough medication is applied to wet the skin and hair of the entire body.
   - 1.3. For pubic lice, apply only to the hairy areas of the genitals and buttocks.
   - 1.4. The medication is applied first without water. Apply enough to wet the area and leave on for 10 minutes. Then apply just enough water to make a lather and massage in like a shampoo.
   - 1.5. Rinse the area well with water. Use a very fine tooth comb (usually provided with medication) to remove the dead lice and nits.
2. Clothing and bed linen should be laundered and clean clothing put on after treatment, under supervision (ICE or DIHS, as per local operating procedures).
3. Personal care items (hair combs and brushes, bath towels, razors, etc.) should be exchanged for new, clean items.

Evaluation:

Refer to a provider for the following:

1. Reaction to pyrethrin, usually a rash;
2. Secondary infection with impetigo, furuncles, or regional lymphadenitis;
3. Treatment failure, consider Lindane by provider prescription.

Education:

1. Emphasize transmission by close contact with other persons and their personal care items, including bed linens and towels; Discourage their sharing of combs, brushes or toiletries with other detainees;
2. Refrain from close contact during treatment and;
3. Refrain from scratching to avoid secondary skin lesions.

MENSTRUAL CRAMPS

Definition: ***Menstrual pain associated with ovular cycles in the absence of pathologic findings.***

Also known as primary dysmenorrhea.

Pain is produced by uterine vasoconstriction, anoxia, and sustained contractions mediated by prostaglandins.

Subjective:

1. Cramping in the mid abdominal area, wave-like in character, lasting one or more days.
2. Associated with nausea, diarrhea, headache, and flushing.
3. Moderate to heavy menstrual bleeding, possibly with clots (average blood loss of 130cc, range 13cc to 130cc).
4. Average duration of menstrual bleeding (usually 5 days plus or minus 2 days).
5. Obtain past history of menstrual cramps, treatment history, date of first day of last menstrual period, and number of pads saturated per day.

Red Flags: Abnormal uterine bleeding (in quantity, timing, or duration) or symptoms suggesting other cause for pain (urinary or gastrointestinal problem). Vaginal discharge, not menses.

Cultural issues:

Some cultures may be more expressive about their pain then others.

Objective:

1. Vital signs are normal.
2. Exam normal or with minimal lower abdominal tenderness.
3. Ensure pregnancy test has been performed and read.

Assessment:

1. Acute pain
2. Risk for activity intolerance
3. Ineffective coping

Plan:

1. Hot packs to lower abdomen.
2. Rest with feet elevated.
3. Refer to *RN Guideline on Pain*, for OTC medication treatment.

Evaluation:

1. Have detainee return to clinic if cramping persists, or if detainee experiences abnormal bleeding.
2. Prescription strength medication may be necessary if cramping is extremely painful.
3. Anemia may result from heavy blood loss.
4. Gastric upset from ibuprofen may occur, especially if taken on an empty stomach.
5. Refer to MD/DO if detainee experiences cramping unrelieved by above treatment.

Education:

1. Explain to the patient that menstrual cramps are temporary and medication should relieve the discomfort.
2. A regular exercise program may be helpful and should be recommended.

MUSCULOSKELETAL PAIN – NON-SPECIFIC FOCAL

Definition: ***Non-specific musculoskeletal pain is characterized by an uncomfortable or acute pain not related to:***

1. Sprain: rapid swelling caused by extravasation of blood within tissues,
2. Strain: swelling, tenderness,
3. Contusion: hemorrhage into injured part.

Subjective:

Chief complaint as described by the patient including:

1. Duration (hours, days, etc.)
2. Aggravating factors (what makes it worse?)
3. Relieving factors (what makes it better?)
4. What precipitated the pain?
5. Prior similar episode/injury?

Cultural issues:

Severity of pain is best indicated by self-report from the patient. Physical signs (grimacing, vocalization, movements, and requests for relief) can be culturally linked.

Objective:

1. Vital signs
2. Pain to palpation over involved area.
3. Decreased range of motion.
4. Edema of affected area.

Red Flag: Refer to a NP/PA/MD/DO if:

1. A limb or joint is edematous, red, and hot to touch.
2. There is a new deformity.
3. The pulse is not palpable.

Assessment:

Acute pain

Plan:

1. Rest
2. Provide crutches, if needed.
3. Ice: apply ice for the first 24 hours (20-30) minutes at a time. Apply heat after 24 hours (4 times a day).
4. Use an elastic bandage to control swelling if needed.
5. Elevation: If in an appendage, elevation may help to reduce swelling.
6. Provide the patient with the special needs form for the duration of time that crutches are used.
7. Medications: Refer to *RN Guideline on Pain*, for OTC medication treatment.

Evaluation:

1. Have the patient return to the clinic if symptoms worsen or change.
2. Return to Clinic (RTC) in 2 weeks if pain persists.

Education:

1. Rest, Ice, Compression, Elevation (RICE)
2. Crutch walking.
3. ROM exercises.
4. Use of medication if given (dose, frequency, duration, side effects).
5. Teach the patient to resume activities gradually and avoid excessive exercise.

NAUSEA AND VOMITING

Definition: Nausea is a feeling of discomfort in the epigastric area.

Vomiting is the forceful expulsion of stomach contents.

The most common cause is gastroenteritis, but other serious causes can include: appendicitis, hepatitis, PUD, pancreatitis, bilary tract disease, intestinal obstruction, drug or food poisoning, kidney stone, or acute neurological disease.

Subjective:

1. Date and time of onset. Are any food or fluids tolerated? Are there any precipitating or aggravating factors: food, alcohol, drugs, odors, position, emotional upset, stress?
2. Duration and timing. Vomiting in the early morning before eating may indicate gastritis or pregnancy.
3. Is nausea always associated with vomiting?
4. Are there any changes in bowel habits? Does pain or cramping occur with diarrhea?
5. Last normal menstrual history.
6. History of weight gain or loss.
7. Is there a history of diabetes, heart disease, alcoholism, liver disease. pancreatitis, gall bladder disease, or ulcers.
8. Review all medications route, time, and dosage as they can cause nausea. Over-the-counter medications such as aspirin, vitamins. and laxative are important. Do any over-the-counter medications relieve symptoms?
9. Is there a history of drug use. or ingestion of substances, or plants? Inquire about use of tobacco products.
10. Nutritional assessment should include: special diet, use of caffeine or alcohol. and recent changes in diet.
11. History of peptic ulcer disease – if yes refer to NP/PA/MD/DO.

Cultural issues:

1. Assess cultural and religious patterns,
2. Patient may be experiencing changes in diet due to detention and change in culture. Daily eating patterns and unavailability of traditional foods may cause significant dietary change.

Age Specific issues:

1. Prolonged vomiting poses threat of aspiration in the elderly,
2. Prolonged vomiting poses a threat of dehydration and electrolyte abnormalities in children.

Objective:

1. Vital signs including height and weight.
2. Mouth & Pharynx
   - 2.1. Inspect the lips for color, symmetry, and presence of abnormalities.
   - 2.2. Assess the tongue, noting color, coating, ulcers, and any variations in size or shape.
   - 2.3. Note any significant mouth odors.
   - 2.4. Assess the pharynx for signs of inflammation and the presence of tonsils, exudate, swelling or ulceration.
   - 2.5. Note the normal retraction of the uvula with an intact vagus nerve.
   - 2.6. Check for CVA tenderness.
   - 2.7. Examine any other area which the patient indicates may have associated symptoms.
3. Abdomen
   - 3.1. Ascultate for bowel sounds and bruits.
   - 3.2. Visualize
   - 3.3. Percuss
   - 3.4. Palpate

Red Flags:

Abdominal pain localized in the right lower quadrant. especially when associated with rebound tenderness may indicate appendicitis.

Vomiting 1 – 4 hours after eating may indicate gastric or

duodenal disease.
Abdominal bruits or visualized pulsation may indicate an abdominal aortic aneurysm.
Protuberant abdomen with bulging flank fluid may indicate ascites.
Neurologic changes and tachycardia may occur with electrolyte imbalance.

Assessment:

1. Risk of fluid volume deficit.
2. Altered nutrition, less than body requirements.
3. Nausea

Plan:

1. Refer to NP/PA/MD/DO if patient meets the criteria for any of the Red Flag circumstances mentioned earlier.
2. Withhold liquids and foods until vomiting is arrested; then begin with clear liquids or crushed ice.
3. Start with juice, iced tea, ginger ale, dry crackers, toast, etc.
4. Encourage soft, bland foods.
5. Avoid highly spiced, fried, or greasy foods, or acid drinks.
6. Encourage eating slowly.

Evalua tion:

1. Return to clinic for daily weight monitoring.
2. Follow-up in 24 hours if N&V persist.
3. Return to clinic if abdominal pain or blood in emesis occurs.

Education:

Educate patient to:
1. Avoid foods that may lead to nausea and vomiting.;
2. Advise to return to clinic if abdominal pain or blood in emesis occurs.

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PAIN

Definition: An unpleasant sensation caused by noxious stimulation of the sensory nerve endings.

Subjective:

1. Describe the cause, location and duration of the pain
2. Describe pain intensity:
   - 2.1. size of the pain area.
   - 2.2. the tenderness within the pain area,
   - 2.3. the effects of movement and pressure on the pain.
   - 2.4. patient's rating of pain intensity, based on a scale of 0-10, with 0 being pain free.
3. Describe pain sensations:
   - 3.1. burning, stabbing, aching, or throbbing pain
   - 3.2. sharp, dull,
   - 3.3. chronic, acute,
   - 3.4. mild, severe,
   - 3.5. precisely or poorly localized or refereed.
4. Describe treatment methods used in the past to successfully treat the pain.
5. Is the pain associated with other factors (e.g., food, empty stomach, position, exercise, movement, urination, menstruation, defecation, sunlight, etc.)?

Age related issues:

Many elderly patients may believe pain is a part of the natural aging process, are ambivalent about the benefits of pain relief, and are reluctant to express pain.

Objective:

1. Vital signs.
2. Pain can cause pallor, diaphoresis, increase pulse rate, increase respiratory rate, increase blood pressure and increase muscle tension.

3. Exam of identified area of pain.

Assessment:

1. Pain.
2. Pain, chronic.
3. Knowledge deficit related to pain control.

Cultural issues:

1. Some cultures are stoic and some may exaggerate symptoms,
2. Be aware of your own views of pain and do not let these influence your assessment.

Plan:

1. A third presentation with same complaint should prompt provider referral.
2. Refer **severe, recurrent, or chronic** pain to NP/PA/MD/DO, for evaluation and possible treatment with prescription medication.
3. Treat the obvious cause(s) of the patient's pain if it is within the scope of RN guidelines or refer to NP/PA/MD/DO if indicated.
4. Those measures that decrease the pain stimuli, such as applications of warm or cold packs may reduce acute pain to the area affected.
5. **Mild to moderate** pain may be treated with OTC medications. Be sure to check for any medication allergies prior to administration.
   - 5.1. Acetaminophen 325 mg. 2 tablets p.o. q.4.h, prn for pain.
   - 5.2. Ibuprofen 200 mg. 1-2 tablets p.o. q.6.h. with food prn for pain
   - 5.3. Aspirin 325 mg. 2 tablets p.o., q.4.h, prn for pain.
6. **Mild** pain can often be relieved by comfort measures and distractions such as reading, exercise, television, and utilizing

relaxation and stress management techniques.

7. Schedule follow-up appointment with patient to ascertain if pain control measures are effective in relieving pain.
8. If pain control measures are not effective, have patient return to clinic ASAP.

Evaluation:

1. Patient reports significant decrease in pain and/or complete pain relief.
2. Patient is compliant with medication administration as prescribed and reports medications are effective in pain control without adverse side effects.

Education:

1. Teach patient the correct indications, dosage, times, routes, and side effects of all prescribed medications.
2. Encourage patient to utilize non-pharmacological methods such as exercise and distraction for control of minor aches and pains.
3. Educate patient about relaxation and stress management techniques to be used as an adjunct to medications in the treatment of pain management.

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SEIZURE

Definition: Episodes of abnormal motor, sensory, autonomic, or psychic activity (or a combination of these) as a consequence of sudden excessive discharge from cerebral neurons.

Subjective:

1. Note history of seizures (new onset versus chronic), diabetes, prior head trauma, alcohol or drug use, cardiac or psychiatric conditions.
2. Note date of last documented seizure and type of seizure.
3. Note recent change or discontinuation of medications.
4. The following should he noted before and during the attack, as most seizures are diagnosed on the basis of focal or general motor activity:
   - 4.1. Description of the circumstances before the attack (visual stimuli, auditory stimuli, emotional or psychic disturbances, sleep, hyperventilation).
   - 4.2. The first thing the patient does in an attack. This information gives clues as to the location of the epileptogenic focus in the brain. When recording, always state whether or not the beginning of the attack was observed.
     - 4.2.1. Where the movements or the stiffness starts, position of the eyeballs and the head at the beginning of the attack.
   - 4.3. The type of movements of the body part involved.
   - 4.4. The body parts involved.
   - 4.5. The size of both pupils. Are the eyes open? Did the eyes/head turn to one side?
   - 4.6. Whether or not automatisms (involuntary motor activity such as lip smacking or repeated swallowing)

were observed.

4.7. Incontinence of urine or feces.

4.8. Did the patient bite his tongue?

4.9. Duration of each phase of the attack.

4.10. Unconsciousness, if present, and its duration.

4.11. Any obvious paralysis or weakness of arms or legs after the attack.

4.12. Inability to speak after the attack.

4.13. Movements at the end of the seizures.

4.14. Whether or not the patient sleeps afterwards.

4.15. Whether or not the patient was confused following the attack.

4.16. Memory loss (with the event).

Objective:

1. Vital signs.
2. Exam including mental status, level of consciousness, any injuries incurred during the episode, and neurologic evaluation.

Assessment:

1. Risk for trauma/suffocation/aspiration
2. Ineffective tissue perfusion
3. Alteration in consciousness related to seizure.
4. Alteration in functioning related to seizure.
5. Deficient knowledge regarding condition and medication control
6. Chronic low self-esteem/disturbed personal identity

7. Impaired social interaction

Cultural issues:

Keep in mind that some cultures and populations, may exhibit intentional seizure like activity, as a reaction to anxiety, or stress. Criminals, for example, may fake a seizure for secondary gains.

Plan:

1. Immediate referral to MD/DO.
2. Supportive care. Do not attempt to physically restrain the detainee.
3. Protect the patient from injury.
   - 3.1. Airway protection, if indicated. When respiration returns following the seizure and the patient becomes flaccid, turn his/her head to the side to facilitate drainage of mucus and saliva and to prevent aspiration.
   - 3.2. Per medical provider's orders: Supplemental oxygen
   - 3.3. Protect against skeletal and soft tissue injury. If ambulatory, ease the patient to the floor if there is enough time. Loosen restrictive clothing. Protect the head with padding if available. Push aside any furniture that the patient may strike during the seizure.
4. Laboratory
   - 4.1. Finger stick glucose to rule out hypoglycemia.
   - **4.2. For new onset seizure, obtain urine drug screen and notify security for room/cell search with MD/DO order.**
5. Other measures

5.1. Place in observation for further management.

5.2. Stay with the patient until he/she is fully conscious.

5.3. Use a calm manner to defuse a potentially embarrassing event for the patient.

5.4. Reorient the patient to his environment when he/she awakens.

5.5. Low bunk. If a short stay unit is available, consider padded side rails and an escort while ambulatory.

5.6. Summon medical assistance if a second seizure follows before consciousness is regained. There is a risk of status epilepticus developing.

5.7. Medication administration as ordered by a provider.

Evaluation:

1. Continue to provide supportive care as above.
2. Watch for seizure recurrence.
3. To follow up with MD/DO as instructed.

Education:

Understanding the disorder and the prescribed medications by the patient and the family, is of the utmost importance; non-adherence to the medication regime has been identified as the single most common reason for treatment failure.

Patient education must be continuous; this topic must be addressed on every visit.

1. Teach patient regarding dosing, actions, side effects, and drug interactions of the particular antiepileptic drug (AED) that is being prescribed.
2. For women of childbearing age or who are taking oral contraceptives, emphasize that AEDs are teratogenic and that they also reduce the effectiveness of oral contraceptives.

3. Review factors that are sometimes associated with seizures such as stimulants, alcohol, caffeine, inadequate sleep, or fever.
4. Advise patient to carry written information in her/his wallet regarding their seizure problem and medications. They can also purchase a medic alert bracelet.
5. Children who are not well controlled should not be given the pertussis vaccine. Consult with the NP/PA/MD/DO.

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SMOKING

Definition: Destructive health behavior involving use of tobacco.

Subjective:

1. Age, race, gender.
2. Duration and quantity of smoking (packs per day).
3. Prior attempts to quit smoking.
4. The length of time between awakening and the first cigarette.
5. Smoke related symptoms: cough, sputum production, shortness of breath, recurrent respiratory infections.
6. Family history and past medical history of tobacco—related diseases.
7. History of lung disease (COPD, asthma, bronchitis).

Objectiv e:

1. Monitor vital signs
2. Examine ears, nose, sinuses, mouth, and pharynx for signs of inflammation.
3. Ascultate heart and lungs.

Assessment:

1. Risk of ineffective airway clearance.
2. Altered health maintenance

Plan:

Follow patient education suggestions below under Education.

Evaluation:

Follow-up every three weeks.

Education:

Patient Education:

1. Instruct patients to stop smoking.
2. Explain the positive health benefits of stopping.
3. Explain the adverse health effects of smoking.
4. Explain effects on fetus to pregnant women.
5. Provide patient education materials.
6. Set a date to stop smoking.
7. Tell patient to ask friends and family for support.

8. Instruct patient to identify things that promote smoking and avoid them.

Providing as little as 3 minutes of education can be effective.

SPRAINS , STRAINS & CONTUSIONS

Definition: Sprain: an injury to ligamentous structures surrounding a joint; usually caused by a wrench or twist, resulting in a decrease in joint stability.

Strain: a microscopic tearing of muscle or tendon caused by excessive force, stretching, or overuse.

Contusion: an injury to the soft tissue produced by a blunt force (such as a hlow, kick, or fall).

Subjective:

1. How did the injury occur?
2. Describe the position of the affected area at the time of the injury.
3. Was the patient able to bear weight after the injury?
4. Did the patient feel a pop or a snap or have any locking of the joint?
5. When was swelling first noticed?
6. Is there any referred or associated pain?
7. Has the patient had any previous injuries?
8. Has any self-treatment been attempted?

Objective:

1. Vital signs
2. Compare injured side with the unaffected side.
3. Examine the most painful area last.
4. Look for swelling. deformity, bruising.
5. Check distal pulses and sensation.
6. Palpation should always be in consistent pattern:

7. Start with the proximal bone structures and move distally, then palpate the surrounding ligaments.
8. Palpate tendons.
9. Perform active range of motion and note degree of flexibility.
10. Perform resistive range of motion to check strength.

Red Flag:

While exercising, the patient had a sudden onset of shooting pain in the calf, followed by weakness in the leg and inability to stand or walk on toes.

The plantar reflex is absent.

Deformity noted.

Absence of distal pulses.

Assessment:

1. Acute Pain
2. Impaired walking

Plan:

1. Elevate the affected part.
2. Apply cold compresses for the first 24 hours (20-30 minutes at a time).
3. Apply heat to affected area after 24 hours (20 – 30 minutes at a time) four times a day.
4. Apply splint if indicated. An ace wrap is usually adequate.
5. Ensure correct use of crutches.
6. Refer to RN Guidelines on Pain for OTC medication treatment.

Evaluation:

1. Evaluate in 7 – 10 days or sooner if pain and swelling do not decrease.
2. Consider referral to NP/PA/MD/DO if symptoms do not improve.
3. Refer immediately if there is any indication of tendon rupture or fracture.

Education:

1. Instruct on **R**est, **I**ce, **C**ompression, and **E**levation.
2. Instruct on the plan of medication.
3. Educate on the need to rest injured part for about a month to allow healing.
4. Teach the patient to resume activities gradually.
5. Advise the patient to avoid excessive exercise of injured part.
6. Teach about need for warm up exercises.
7. Instruct on use of crutches.

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STRESS

Definition: ***The effect produced when a structure, system, or organism is acted upon by a stressor (an agent or condition capable of producing stress).***

Detainees incarcerated in the various ICE detention sites often suffer stress and anxiety, as a result of being detained and away from their significant others.

Refugees may be fleeing war and political persecution.

Many may be experiencing symptoms of Post Traumatic Stress Disorder (PTSD).

Subjective:

1. Patient may complain of increased tension, feelings of helplessness, inadequacy, apprehension, uncertainty, being scared, over excitedness, may give description of fight/flight behavior.
2. May complain of difficulties sleeping, early a.m. awakening, frequent somatic complaints, loss of appetite, or increased appetite.
3. May complain of weight loss, palpitations, shortness of breath, chest tightness, sweating, hands shaking, diarrhea, nausea, increased difficulty with other detainees and authority and may have withdrawal.

Red Flag: Talks about wanting to hurt self, thinking about suicide, talking about giving belongings away. Has extreme feelings of paranoia, or delusional behavior, or thoughts.

Objective:

1. Provide privacy and calm atmosphere.
2. Vital signs. Note palpitations, elevated pulse/respiratory rate.
3. Note body language. Is there facial tension? Wide eyes?

Startle response? Eye contact? Shaking hands, clenched fists, extraneous movement, inability to sit still? Furrowed brow, clinging to staff, family member?

4. Note whether patient concentrates on one thing at a time. Observe speech content and patterns: rapidity/slowed, pressured, words used, repetition, laughter.
5. Chart review: Does patient have a prior history of anxiety and if so, treatment.

Red Flag: Patient attempts to hurt self, or physically lashes out. Patient is unable to sit still.

Cultural Issues:

In Asian culture, a stigma is attached to mental illness and emotional problems may be somatized. In other cultures, the presentation of their symptoms may be out of proportion (exaggerated) to the actual situation.

Assessment:

1. Anxiety due to situation, separation from support system, environmental stimuli, unmet needs.
2. Post-trauma syndrome
3. Ineffective coping
4. Complicated grieving
5. Interrupted family processes

Plan:

1. Acknowledge fear/anxieties/stress. Validate observations with patient, e.g., "You seem anxious, stressed." Feelings are real and it is helpful to bring them out in the open so they can be discussed and dealt with. Assess degree/reality of threat to patient and level of anxiety (mild, moderate, or severe).
2. Identify patient's perception(s) of the situation.
3. Evaluate coping/defense mechanisms used in the past (problem solving skills, asking for help).
4. Assist patient in using anxiety for coping with the situation when possible (moderate anxiety heightens awareness and

can help the patient focus on dealing with problems).

5. Acknowledge feelings as expressed (this will enable the patient to deal more appropriately with the situation). If actions are unacceptable. take necessary steps to control/deal with behavior (does patient have prn order for anxiety).
6. Avoid empty reassurances that "everything will be alright".
7. Encourage patient to develop exercise /activity program (walking, English or other classes if available. develop a friendship, write down feelings). Can encourage attendance at religious services.
8. Encourage/instruct in mental imagery/relaxation methods; e.g. Imaging a pleasant place, slow breathing, meditation, prayer).
9. Administer prescribed medications as ordered.
10. Refer to NP/PA/MD/DO, or psychologist/psychiatrist ASAP, if patient has a moderate to a high degree of anxiety (obvious impairment in activities of daily living).

Evaluation:

1. Follow-up in one week, or advise patient to return to clinic sooner if feels he needs to see a provider before his scheduled appointment.
2. Follow-up with medical provider as ordered.

Education:

Advise patient to return to clinic ASAP if they have suicidal ideation.

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SUICIDE

Definition: The act of taking one's own life.

The eleventh leading cause of death in the United States in 2005 according to the CDC.

The third highest cause of death for those age 15-24 in 2005 according to the CDC .

Subjective:

1. Risk factors:
   - 1.1. Associated psychiatric illness (affective disorders and substance abuse in adults, behavioral conduct disorders in young people).
   - 1.2. Personality traits related to suicide (aggression, impulsivity, depression, hopelessness, borderline personality disorder, antisocial personality).
   - 1.3. Persons who have experienced early loss, decreased social support, chronic illness, recent divorce.
   - 1.4. Genetic and familial factors (family history of suicide, certain psychiatric disorders or alcoholism, alcohol and substance abuse).
   - 1.5. Past history of suicide attempt.
   - 1.6. Religious convictions.
2. Suicidal ideation
   - 2.1. Patient may communicate suicidal intent directly or indirectly, manifesting as preoccupation with death or talking of someone else's suicide.
   - 2.2. Does the patient have a specific plan for suicide?
   - 2.3. Does the patient have the means to carry out the plan?
3. Suicide attempt
   - 3.1. Assess extent of injuries.
   - 3.2. Document circumstances surrounding the event as completely as possible.
     - 3.2.1. Method of injury (laceration, hanging, ingestion of substance, etc.),
     - 3.2.2. Type and/or quantity of device (knife, bed linen noose, type and number of pills ingested, etc.),

3.2.3. Timing of attempt (when were the pills taken, when was the patient discovered, etc.)

Cultural issues:

Some cultures, for example the Japanese, do not have a social stigma associated with suicide. Furthermore, some cultures "lose face" if detained or get in trouble and may be more likely to act out or attempt suicide.

Objective:

1. Vital signs and exam, specific to complaints and/or injury.
2. Ask specifically about suicidal ideation, as above.

Assessment:

1. Alteration in comfort related to suicide attempt.
2. Injuries actual/potential related to suicidal ideation.
3. Hopelessness
4. Risk for suicide
5. Chronic/situational low self-esteem
6. Compromised family coping

Plan:

1. Do not leave the patient alone and provide for the patient's immediate safety
2. Follow the current DIHS Standard Operating Procedure for suicide at all times.
3. Notify MD/DO and mental health immediately.

Evaluation:

Arrange follow up as per the current DIHS Suicide Protocal
Continue to monitor for suicidal ideation/ suicide potential.

Education:

Advise patient to notify any staff member immediately if he/she has suicidal ideation. Explain they need to talk with someone if they are having thoughts of suicide and possibly a plan on

carrying it out.

SUTURE/STAPLE REMOVAL

Definition: The withdrawal of artificially inserted polyfilament thread or steel fastener used to repair a laceration.

Subjective:

Any complaint of complications.

Objective:

1. Vital signs.
2. Appearance of the wound.
3. Sutures and staples are typically removed after several days. This varies for each body part as follows:
   - 3.1. Face.....3 – 4 days
   - 3.2. Neck.....5 days
   - 3.3. Scalp.....6 – 7 days
   - 3.4. Arms, back of hands.....7 days
   - 3.5. Chest and Abdomen.....7 – 10 days
   - 3.6. Legs and top of feet.....10 days
   - 3.7. Back .....10 – 12 days
   - 3.8. Palms of hands, soles of feet.....14 days

Assessment:

1. Impaired skin integrity
2. Risk for infection.

Plan:

1. Remove sutures/staples per medical provider's orders.
2. Assemble equipment:
   - 2.1. Scissors (sterile),
   - 2.2. Staple removal (sterile),
   - 2.3. Forceps without teeth (sterile),
   - 2.4. Gloves (Sterile),
   - 2.5. Hydrogen peroxide.
   - 2.6. Cotton tipped applicators,
   - 2.7. 4x4 gauze,
   - 2.8. Steri strips or butterfly closures with tincture of benzoin compound.

3. Procedure:
   - 3.1. Position the client comfortably with wound site easily accessible.
   - 3.2. If crust is present over wound site:
     - 3.2.1. Gently roll a cotton tipped applicator saturated with hydrogen peroxide over the site to remove crust.

3.2.2. Rinse with a cotton tipped applicator saturated with 0.9% sodium chloride.
3.2.3. Blot the site dry.
3.3. Examine wound line to determine the type of technique used.

3.3.1. Standard suture removal:
3.3.1.1. Locate the end tie knot.
3.3.1.2. Grasp the tip of the suture with forceps and gently lift upward on the suture.
3.3.1.3. Cut the suture.
3.3.1.4. Gently remove the suture.
3.3.1.5. Repeat this procedure until all sutures are removed.

3.3.2. Running suture line technique:
3.3.2.1. Cut the knot at the distal end of the suture line.
3.3.2.2. Grasp the opposite knot with forceps.
3.3.2.3. Pull gently with a continuous steady motion until suture is removed.

3.3.3. Small loop sutures, closed sutures, and difficult anatomical position sutures:
3.3.3.1. Take No. 11 scalpel and place flat on skin.
3.3.3.2. Slide the scalpel under the suture and exert the sharp edge against the suture.
3.3.3.3. Use forceps to remove the suture.

3.3.4. Staple removal:
3.3.4.1. Insert the bottom prongs of staple remover under a staple and depress the top handle.
3.3.4.2. Edges of the staple will rise.
3.3.4.3. Rock the staple gently side to side, if needed, to remove edges of the staple from the skin.
3.3.4.4. Continue with each staple until all staples are removed. If there appears to be separation, remove only every

other staple.

3.3.4.5. Cleanse incision with alcohol prep pads.

3.4. Blot the area dry as needed with 4x4 gauze.

3.5. If the wound line appears slightly unstable, a steri strip or butterfly may be used.

Evaluation:

Return to clinic if signs of infection.

Education:

1. Observe for signs and symptoms of infection:
   - 1.1. Increase in pain after 24 hours.
   - 1.2. Increase in temperature.
   - 1.3. Redness or swelling.
   - 1.4. Yellow or greenish drainage.
   - 1.5. Foul odor.
   - 1.6. Wound separation.
   - 1.7. If steri strips are used, remove in 24 – 48 hours.
   - 1.8. Keep area clean and dry.

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THROAT , SORE

Definition: Inflammation of the pharynx surrounding lymph tissue.

Subjective:

1. Chief complaint.
2. Date of onset.
3. History of fever and chills.
4. Question history of rhinorrhea or cough.
5. Associated symptoms: headache, fatigue, muscle aches, abdominal pain.
6. Determine if swallowing is affected.

Objective:

1. Vital signs.
2. Inspect skin texture, turgor and erythematous rash.
3. Inspect mouth for lesions.
4. Visualize throat and pharynx for exudate and swelling
5. Palpate for lymph nodes.
6. Auscultate chest.
7. Exudates on throat or tonsils may indicate group A

streptococcal infection (strep throat) and require a referral to an NP/PA/MD/DO

8. Fever >101 F should be referred to a NP/PA/MD/DO.

Red Flag:

1. Nuchal rigidity requires immediate referral to the MD/DO.
2. Mental status changes require immediate referral to the MD/DO.
3. Unilateral swelling on one side of throat may indicate peritonsillar abscess and necessitates immediate referral to a NP/PA/MD/DO.
4. Diffuse patchy exudate may indicate candida albicans resulting from HIV or antibiotic usage and should be ***referred.***
5. Drooling or inability to swallow should be immediately referred to a MD/DO.

Assessment:

1. Risk for infection.
2. Risk for fluid volume deficit.
3. Risk for alteration in respiratory status.
4. Deficient knowledge

Plan:

1. Increase fluid intake (juice, water, carbonated beverages) to at least 8 – 8 ounce glasses per day.
2. Saline gargles (1 tsp. of salt in 8 oz water) 3 to 4 x per day
3. Medications:
   3.1. Refer to RN Guideline on Pain, for OTC medication treatment.

Evaluation:

Follow-up in 3 –4 days if there is no improvement or if swallowing becomes difficult.

Education:

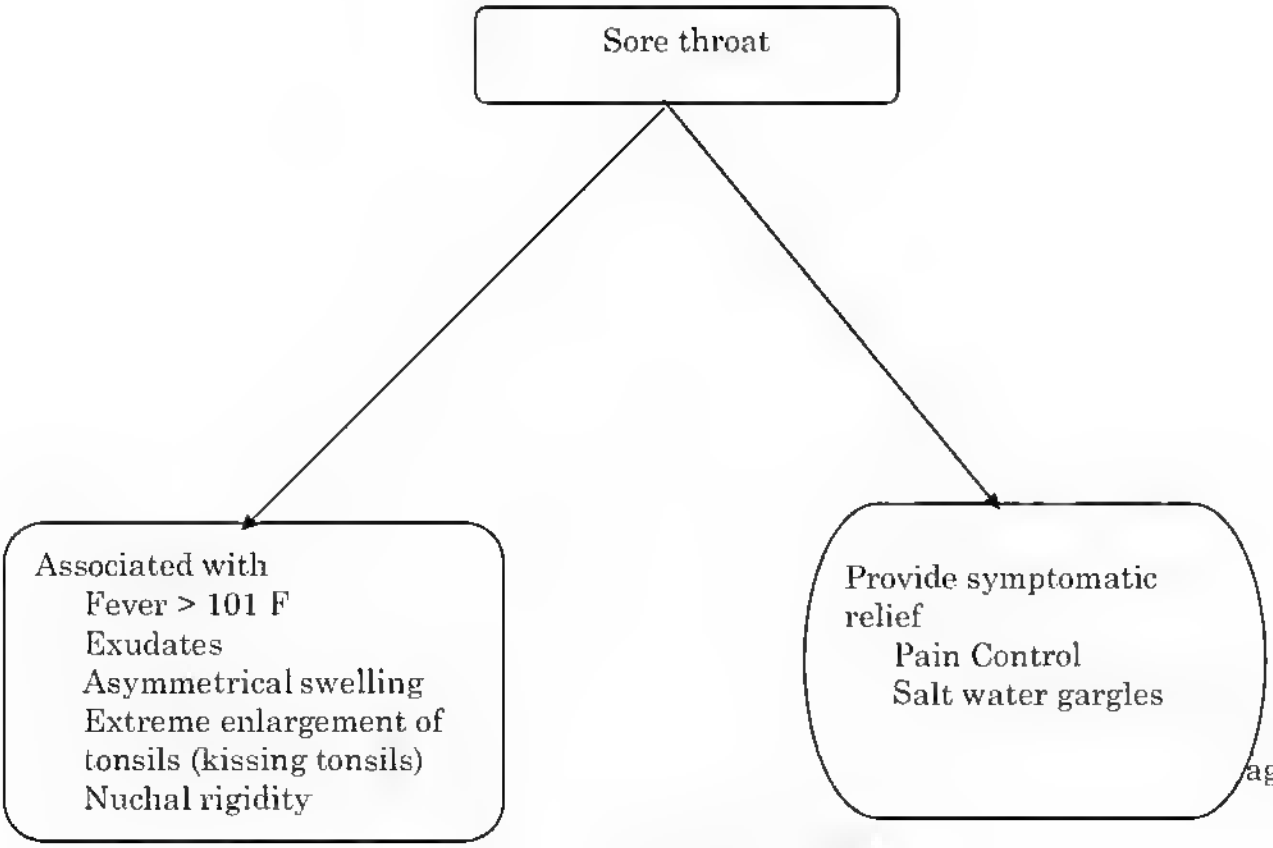
1. Instruct to increase fluids. Give detailed instructions on ounces and assure that they have ready access to fluids.
2. Hot liquids, carbonated beverages, saline gargles, and lozenges may be soothing. Milk in not advised.
3. Reinforce that antibiotics are not helpful with viral

infections.

Cultural issues:

1. Some cultures have beliefs about what foods should be eaten when sick. The HOT-COLD classification of foods is common among Mexicans and Chinese. Inquire about what has helped them in the past and try to guide them
2. Chinese have used health foods and herb tonics to cure illness. Guide within limits on detainee dietary choices.

SORE THROAT



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TINEA PEDIS

Definition: Infection by a fungi that has the ability to infect and survive only on the keratin.

Predisposing factors include debilitating diseases, poor nutrition, poor hygiene, tropical climates, and contact with infected persons or surfaces.

Subjective:

1. History of being barefoot in a public shower.
2. History of poor nutrition.
3. Immune deficiency.
4. Onset, duration, distribution, presence of symptoms
5. Any current treatments used and the outcomes
6. Usually itches.

Objective:

1. Vital signs.
2. Type and distribution of lesions.
3. Lesions are fine, vesiculopustular or scaly.
4. Use of Wood's lamp may be useful.
5. Location: any area of the foot may be involved, but likely to occur on the instep or between the toes.
6. Look for cracking and secondary infection/ulceration particularly in diabetics. If present, refer to provider.

Assessment:

1. Impaired skin integrity
2. Risk for infection
3. Deficient knowledge

Plan:

1. Thoroughly wash and dry area daily, using a clean towel each day.
2. Assure that the detainee has shower shoes.
3. Medication:
   3.1. Clortrimazole 1% cream, apply to affected area b.i.d.

Evaluation:

Return to clinic if signs of infection develop.

Educat ion:

1. Wash and dry thoroughly daily. Use a new towel each day.
2. Wear shower shoes in the shower.
3. Clean shower shoes each week.
4. Wear clean socks daily. Put socks on before underwear.
5. Instruct on proper application of medication and on other antifungal medications that may be available.
6. Explain that fungal infections thrive in warm, damp areas and sunlight or open air on affected area will help.
7. Explain duration of treatment..

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UPPER RESPIRATORY TRACT INFECTIO N

Definition: An acute, mild and self-limiting syndrome caused by a viral infection of the upper respiratory tract mucosa.

Subjective:

1. Chief complaint with days of duration.
2. Respiratory distress including; wheezing, dyspnea, stridor.
3. Inability to swallow.
4. Fever, chills, anorexia, nausea, vomiting and diarrhea.
5. Facial, head, ear, throat, or chest pain.
6. Use of any over the counter medications.
7. History of allergies or asthma.
8. History of tobacco use (quantity & years).

Red Flag:

Drooling or a severe headache necessitate an immediate referral to NP/PA/MD/DO.

Objective:

1. Vital signs.
2. Ascultate heart and lungs.
3. Examine conjunctiva, ears, nose and throat.
4. Sinus percussion and transillumination.
5. Palpate lymph nodes.

Assessment:

Ineffective airway clearance.
Ineffective breathing pattern

Plan:

1. Increase fluid intake (juice, water, carbonated beverages) to eight 8-ounce cups per day.
2. Salt water gargle for sore throat (1 tsp. salt with 8 oz warm water)

3. Increase humidity in the air. This can best be accomplished by having the detainee hang a wet towel over the head of the bed.
4. Steamy showers or inhalation of steam may help.
5. Warm fluids such as tea and chicken soup can increase the rate of mucous flow.
6. Increase rest.
7. If detainee has a food service job, they may need a special needs form to be off work for three days.
8. Medications:
   - 8.1. Topical decongestants should be used no longer than 3 days.
   - 8.2. Saline spray, 2 puffs, qid prn each nare.
   - 8.3. Oral decongestants:
     - 8.3.1. Pseudoephedrine hydrochloride 60 mg, 1 tablet q 4 – 6 hours for 3 days.

       OR
     - 8.3.2. Chlorpheniramine maleate 4mg 1 tablet every 4-6 hours, not to exceed 24mg/day

       OR
     - 8.3.3. Pseudoephedrine/Chlorpheniramine/Acetaminophen (Coricidin-D) 1-2 tables q 8 brs prn
   - 8.4. Cough suppressant:
     - 8.4.1. Dextromethorphan 15 mg lozengers. Dissolve one in mouth Q4 hrs, prn. Do not exceed maximum dosage of 6 lozengers in 24 hours.

       OR
     - 8.4.2. Dextromethorphan HBr 10 mg and Guafenesin 100 mg liquid. Two teaspoons Q 3 to 4 hours. Do not exceed 8 doses in 24 hours.
   - 8.5. Analgesics:
     - 8.5.1. Acetaminophen 325 mg, 2 p.o. q.i.d. prn x 3 days.

       OR
     - 8.5.2. Ibuprofen 200 mg, 2 p.o. q.i.d. prn x 3 days.

Cultural issues:

Some cultures have beliefs about what foods should be eaten when sick. The HOT-COLD classification of foods is common among Mexicans and Chinese. Inquire about what has helped them in the past and try to guide them.

Chinese have used health foods and herb tonics to cure illness. Guide within limits on detainee dietary choices.

At sites with commissaries or canteens, detainees may have access to these choices.

Evaluation:

Return to clinic in 3 days if symptoms persist or sooner if increased fever or difficulty breathing.

Education:

1. Review the etiology, course, and proper treatment of the common cold.
2. Instruct on increased fluids (provide an amount).
3. Proper use of medications.
4. If they smoke give information on smoking cessation.
5. Instruct on proper hand washing.

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WOUND CARE

Definition: Severed skin; a cut that does not penetrate beyond the first layer of skin.

Red Flag: Refer all patients needing sutures or who have puncture wounds to an NP/PA/MD/DO.

Subjective:

1. When did the wound occur.
2. What was the cause.
3. Nature and etiology of the injury: Inconsistencies may indicate systemic problems (fights, seizures, heart problems, abuse).
4. When was the last tetanus shot?

Cultural issues:

Many countries may not routinely give tetanus prophylaxis. Confirm that the patient still has active protection from tetanus.

Objective:

1. Note:
   - 1.1. The size and depth of the wound. Wounds deeper than the first layer of skin may require sutures.
   - 1.2. Length of time between initial infliction of wound and patient seeking treatment.
2. Describe:
   - 2.1. Any drainage.
   - 2.2. Amount of bleeding, and whether controlled.
   - 2.3. Degree of contamination; presence of foreign body.
   - 2.4. Nerve, tendon, bone, or other vital structure involvement.
   - 2.5. Motor, sensory, and circulatory function.

3. Describe the type of wound:
   3.1. Incision,
   3.2. Laceration,
   3.3. Puncture,
   3.4. Avulsion,
   3.5. Contusion.
4. Note any signs of infection:
   4.1. Redness,
   4.2. Swelling,
   4.3. Increased pain,
   4.4. Streaking,
   4.5. Pus.

Red Flag:

1. Summon help immediately if arterial bleeding is suspected or if bleeding is severe.
2. Laceration of the head associated with change in mental status requires immediate referral.
3. Puncture wounds through tennis shoes should be referred. They are at increased risk of infection.
4. Red streaking, espeeially when associated with fever, should be referred immediately.
5. Lacerations of or around the eye should be referred to an NP/PA/MD/DO.
6. Bites should be referred to a NP/PA/MD/DO and should not be sutured.
7. Refer to NP/PA/MD/DO if wound is over 12 hours old and patient exhibits any signs or symptoms of infection whether locally or systemically.

Assessment:

1. Impaired skin integrity.
2. Risk for infection.
3. [Acute/chronic] Pain related to disruption of skin integrity and possible exposure of nerves and underlying tissue.

Cultural issue:

Darker skinned individuals are at greater risk for developing keloids.

Age specific issues:

Older clients heal less well and wounds are likely to become infected. They should be instructed on increased vigilance for S&S of infection.

Plan:

1. **General:**
   - 1.1. Control hleeding using direct pressure with sterile dressing and raising extremity above heart level or applying pressure to pulse points if necessary.
   - 1.2. Minor wounds should be irrigated with normal saline or wound irrigation solution as ordered by the NP/PA/MD/DO.
2. **Laceration:**
   - 2.1. Position client with the wounded area easily accessible.
   - 2.2. Wash wound thoroughly with an antibacterial soap assuring that no foreign bodies are in the wound.
   - 2.3. Cleanse skin 3 inches around the wound with antiseptic skin cleanser.
   - 2.4. Apply steri strips or butterfly closures if the edges of the wound are not approximated.
     - 2.4.1. Using cotton-tipped applicators, apply tincture of benzoin or other skin adhesive. Start next to the wound edges and extend outward approximately 1 ½ inch.
     - 2.4.2. Allow the skin adhesive to become tacky.
     - 2.4.3. Apply steri-strips to the wound. pulling one skin edge toward the other.
     - 2.4.4. Apply a sufficient number of steri strips to ensure wound closure.
   - 2.5. Apply an antibiotic ointment and a clean, nonocclusive dressing.
   - 2.6. If tetanus prophylaxis is indicated see a provider for an order.
3. **Abrasion:**
   - 3.1. Clean area thoroughly, with a brush if necessary to

remove dirt.

3.2. Irrigate thoroughly with normal saline.

3.3. Apply a thin layer of triple antibiotic ointment to prevent crusting.

4. Set up suture equipment as needed or ordered for deeper wounds or wounds requiring sutures.
5. Pain Management

5.1. For medications, refer to *RN Guideline on Pain* for OTC treatment.

5.2. Medicate as ordered by NP/PA/MD/DO.

Use of hydrogen peroxide, alcohol, or betadine is generally contraindicated with most wounds.

Evaluation :

1. Patient demonstrates proper wound care and/or dressing changes as previously instructed.
2. Patient is able to correctly describe signs & symptoms of infections.
3. Follow-up in the clinic only if signs of infection occur.

Education:

1. Keep area clean and dry.
2. Any increased pain, pus, drainage, foul odor, red streaks, redness, swollen lymph nodes, fever, or chills, may indicate infection and the patient should return to the clinic.
3. If a dressing is applied over a steri strip area remove it after 24 hours and leave the area open to air.
4. A small amount of redness around the wound is normal.
5. Instruct patients with abrasions to clean area several times a day.

WOUND CARE